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THE Universal Medical Journal

(FORMERLY THE SATELLITE).

A MONTHLY MAGAZINE

OF THE

Progress of Every Branch of Medicine in all Parts of the World.

EDITED BY

CHARLES E. SAJOUS, M.D.,
EDITOR-IN-CHIEF OF "THE ANNUAL OF THE UNIVERSAL MEDICAL SCIENCES."

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Selections from Society Proceedings.

FRANCE.

SOCIÉTÉ MÉDICALE DES HÔPITAUX.

Treatment of Appendicitis.—The meeting was almost exclusively devoted to the discussion of the treatment of appendicitis and perityphlitis,—a discussion which arose after the reading of a paper on the subject at the last meeting by M. Millard, in which medical treatment was advocated to the almost entire exclusion of surgical measures. There was a consensus of opinion that surgeons generally for the past several years have shown a too marked tendency to operate in such cases. Clinical observation proved, in their minds, that the disease can be cured in the majority of cases without operation. M. DU CAZAL, who sees five or six cases a year in young soldiers at the Val-de-Grâce hospital, agreed completely with M. Millard, that the disease was one for medical treatment mainly. The other speakers differed from this more or less, and believed that while operation should not be undertaken in all cases, while intervention should be rarer than non-intervention, it was absolutely necessary in a certain number of instances. Surgical treatment was indicated (1) in cases of generalized peritonitis from perforation; (2) in perforating appendicitis having an acute course; (3) in cases in which the purulent collection had reached a certain volume; (4) in recurrent cases of appendicitis. These indications, it may be remarked, are almost exactly the same as those given by M. Talamon in his work upon the subject.

MM. LE GENDRE, SEVESTRE, and MOIZARD were of accord in declaring that the patients should be most carefully watched, and, should any doubt as to the line of action arise, operation should be preferred. A diagnosis should, if possible, be made between perityphlitis of stercoral origin and appendicitis. This can be done in a certain number of cases.

M. Moizard observed that typhlitis is rarely met with in children, and that in them one has always to do with appendicitis, the disease taking a more acute form than in adults; hence there should be less hesitation in operating on a child.

M. Albert Mathieu, without denying the existence of typhlitis, thought that it was better not to delay making the differential diagnosis; it would be more advantageous to the patient to admit an appendicitis which did not exist than to fail to recognize an appendicitis which did exist. Typhlitis due to cæcal engorgement seemed to require energetic purgation from the outset, but with appendicitis much greater prudence in this direction was necessary.

All four of the speakers deprecated the use of purgatives in appendicitis. On the contrary, the patients should be completely immobilized, as it were, and large doses of opium or morphine administered without fear. Purgatives should be given only when the local symptoms show less intensity, and when the danger of perforation and generalized peritonitis is less. Time should be allowed for the formation of protecting adhesions, which prevent the entrance of pus into the peritoneal cavity. Purgatives, when used, should be very mild, preference being accorded to castor-oil, the action of which can be regulated by giving teaspoonful doses. The first day of purgation but one teaspoonful should be administered; later on several such doses may be given in a day, one at a time, an hour apart.—*Gazette des Hôpitaux*, December 11, 1894.

In continuing the discussion on the same subject, M. Rendu stated, as the result of his observations, that the immense majority of cases of perityphlitis in the adult recover under medical treatment, without any necessity for surgical measures. Appendicitis, especially in children, is much more grave, but it is rarely that death results from the first shock which follows intestinal perforation. It is usually within the five or six days following, when there is an abatement of the symptoms leading one to suppose that convalescence has set in, that the patients succumb to unexpected symptoms. Medical treatment should therefore be begun at once, and the surgeon should not be called in at the first appearance of peritoneal symptoms, but only when a purulent encysted collection is definitely ascertained to be present. The speaker alluded to the statistics given by M. Mathieu at the previous meeting, showing that even in England, where surgical measures are so boldly undertaken, the plan of medical treatment in these cases is steadily gaining ground.

M. Huchard had recently observed a case in a patient 20 years of age, who was operated upon almost *in extremis*, and in whom there was perforation of the appendix with purulent peritonitis, almost generalized. The man died during the night. It was found that three years previously he had had typhlitis, a small induration in the iliac fossa remaining, which was from time to time the seat of some pain. This case proved, in the opinion of the speaker, that a fatal appendicitis may result from a previous typhlitis, and that, if surgical operation had been undertaken at the time of the first attack or upon the re-appearance of pain, the patient's life might have

been saved. The possibility of appendicitis following a cured perityphlitis should always be borne in mind as long as the inflammatory induration and pain in the iliac fossa persist.

M. FERRAND, in closing the discussion, called attention to a point in regard to the administration of opium,—a drug which had been advised by so many of the members participating in the debate. Without disputing its value, he believed that opium diminished intestinal secretion and favored, to a certain extent, fæcal stasis, the consequences of which are so disastrous in some cases of typhlitis. Belladonna, it seemed to him, might be substituted for opium with advantage. For his own part, he had so little fear of intestinal movements, in these cases, that he did not hesitate to give injections of senna when necessary. In spite of the colic which these occasion, they have the great advantage of assuring asepsis of the intestinal canal.—*La Semaine Médicale*, December 12, 1894.

Hepatic Abscess following Appendicitis.—M. ACHARD reported a case of suppurative hepatitis consecutive to appendicitis. A diagnosis of perihepatitis had been made during life, and, as the coli bacillus was found in the pus removed by exploratory puncture, the pericæcal origin of the suppuration could be almost affirmed before death. The case proved, upon post-mortem examination, to be one of areolar abscess developed about the subhepatic veins,—a comparatively rare condition, which appears to be more likely to occur in subacute forms of appendicitis.—*Gaz. des Hôpitaux*, November 20, 1894.

ACADÉMIE DE MÉDECINE.

Syphilis and General Paralysis.—In discussing the relation between syphilis and general paralysis, PROFESSOR FOURNIER gave the name of pseudo-general paralysis to a form of cerebral syphilis presenting appearances almost exactly the same as those of true general paralysis, just as certain other forms resemble epilepsy or aphasia. He considers it an undoubted fact that syphilis is a potent factor in general paralysis,—a fact proven by the frequency of a syphilitic family history (50 to 92 per cent., according to statistics); by the number of syphilitics who develop general paralysis; by the rarity of general paralysis among women, except among those who have led irregular lives; by its rarity in the country, among ministers and persons belonging to religious orders; by the frequency of syphilitic antecedents in general paralysis as compared with other forms of insanity; by the association of general paralysis with tabes, in which syphilis is now accepted as an etiological factor; by the occurrence of general paralysis in young persons with syphilitic antecedents, and in whom the disease cannot be ascribed to excesses, immorality, or inebriety. While convinced that a great many cases of general paralysis proceed from syphilis, and would have never developed had the patients not contracted that disease, Professor Fournier does not agree with the opinion expressed by some authors that general paralysis is a direct consequence of syphilis,—a simple specific symptom, such as a gumma, a mucous patch, or a chancre,—for one reason, among many others, that general paralysis is not influenced

by mercury or iodide. He is inclined to class the disease among the para-syphilitic cases, which, though incontestably of syphilitic origin, are not syphilitic in themselves, and do not necessarily and exclusively depend upon syphilis as the cause. Such are tabes, infantilism, hysteria, hydrocephalus, etc.

The question as to whether true general paralysis following syphilis can be differentiated by any clinical, anatomical, or other symptom from paralysis due to other causes, is one which Professor Fournier does not attempt to answer in his rôle of simple syphiligraphist, as he believes it to be a question that can only be answered by the collaboration of alienists, anatomo-pathologists, and syphiligraphists. He has been struck, however, with the fact that the general paralysis of syphilitic patients sometimes begins with symptoms of tabes, or that it is associated with tabes, forming a sort of hybrid combination which he has designated as cerebro-spinal tabes. He has seen tabes frequently turn into general paralysis, and the reverse, as well as the two diseases developing together, but he cannot affirm positively that such a combination of symptoms is not to be met with outside of syphilitic cases, though he believes that it is not.—*Archives Générales de Médecine*, December, 1894.

GREAT BRITAIN.

Clinical Society of Manchester.

Traube's Sign.—Dr. Graham Steell related the case of a patient with aortic incompetence, who afforded an example of Traube's sign,—a double sound in the femoral artery. Dr. Steell said he had, in Berlin in 1872, been shown a patient with the sign, and since that he had been looking out for an example of the sign in his own country, but without success till a few weeks ago. He pointed out that Traube's sign consisted of sounds resembling the normal heart-sounds, and not of murmurs as the sign of Duroziez, which, moreover, unlike Traube's sign, required pressure upon the artery with the stethoscope to bring it out. Traube regarded his rare sign as indicative not merely of aortic incompetence, but of very free regurgitation and much dilatation of the left ventricle. Dr. Steell's case bore out this belief.

Dry Mouth, or Xerostomia.—Dr. Thomas Harris showed a woman, aged 30, who had had good health until three or four years ago, when the disease made its appearance. Mouth was absolutely dry, and there was a complete arrest of secretion of all the salivary and buccal glands. There was also a decided enlargement of the parotid glands. The woman was anæmic, but all the organs appeared healthy. There was no disease of the pelvic viscera. Dr. Harris referred to the very few cases of the malady which had been recorded, and especially to two cases of relapsing parotitis recorded by Mr. Jonathan Hutchinson, one of which was associated with a certain amount of dry mouth. Dr. Harris regarded xerostomia as a functional nervous affection, and thought that probably the parotid enlarge-

ment had a similar cause, and referred to Mr. Stephen Paget's communication on the relation of parotitis to injuries and diseases of the abdominal and pelvic viscera.—*British Medical Journal*, December 8, 1894.

ACADEMY OF MEDICINE IN IRELAND.

Operation for Cancer of the Jaws and Tongue.—SIR WM. STOKES gave the details of a series of cases of cancer of the upper and lower jaws, the tongue, and the floor of the mouth, which had been under his care in the Richmond Surgical and Meath Hospitals. He warmly advocated an early operation in such cases, and expressed the opinion that, even when the disease is fully developed, surgical intervention may give great relief and prolong the life of the patient.

The president, PROF. THORNLEY STOKER, expressed his strong belief in the relation between cancer of the tongue and syphilis. The number of cases of doubtful disease proved to be cancer, and the number of undoubted cases of syphilis which eventuated in cancer must have struck every surgeon of experience. He was not much in favor of operations on the tongue, but, if undertaken, he believed that the entire organ should be removed. Plastic operations, when not absolutely necessary, should be deprecated.

MR. CROLY considered it better surgery to remove the whole rather than a part of the tongue, especially as complete removal did not prevent articulation. When the disease returned, it nearly always did so in the glands of the neck.

MR. WHEELER did not approve of the removal of the entire tongue when only a small portion was involved. He advised the use of the thermocautery scissors, not too much heated. He concurred in the belief that syphilis was a potent factor in producing cancer of the tongue.

MR. THOMSON was also of the opinion that the tongue should be entirely removed, since infection was known to follow even a very small ulcer. The return of cancer of the tongue was so frequent that he was rather inclined to look upon cases of non-return as mistakes in diagnosis.

MR. MYLES insisted on the necessity of removing any enlarged glands. A ligature passed around the root of the tongue was of no value in checking hæmorrhage from the lingual arteries, since these are present only in the anterior portion of the tongue. He denounced the écraseur as having a tendency to travel in the direction of least resistance, and so to encroach upon the easily broken-down cancerous mass.

MR. TOBIN emphasized the importance of opening the digastric triangle and removing any infected glands. When preliminary tracheotomy was performed it was better to remove the tube at once, and thus lessen the tendency to septic pneumonia.

MR. FRANKS thought it would be a mistake to remove the whole tongue if there were only a small ulcer on the side, well away from the middle line, as the tendency of the disease was to follow the lymphatic channels to the glands, not to cross the middle line. Even if the operation were not successful, owing to the return of the disease in the glands of the

neck, it was justified by the relief afforded the patient. Galvano-cautery had the great advantage of speed as compared with the écraseur. He followed Mr. Whitehead's method of excising the tongue, and was never troubled with secondary hæmorrhage. He considered Rose's position the ideal one in operations about the mouth.

SIR WILLIAM STOKES, in replying, said that he had seen, both in his own country and Germany, many cases of excision of the jaw in which preliminary tracheotomy had not been performed. He agreed that any plastic operations should be entirely secondary to thorough removal of the disease. An imperfect operation was sometimes permissible to relieve the patient of a fetid ulceration in the mouth, although complete removal of the disease could not be hoped for. He had a personal dislike to the thermo-cautery, secondary hæmorrhage having occurred in two cases in which he had used it.—*Medical Press and Circular*, December 5, 1894.

HUNTERIAN SOCIETY.

Syphilis of Spinal Cord.—DR. FRED. J. SMITH showed a case of syphilitic disease of the spinal cord in a man, aged 29, who suffered from syphilis eighteen months before admission. He first complained of stiffness and pain in the back last Easter. Some six weeks after this he was thrown out of a trap, but felt no ill effects from the accident. A fortnight later he lost power in the legs rather rapidly, and took to his bed for three weeks, improving under medical treatment. On Saturday, September 8th, he fell down from weakness in the legs, and on September 13th, on admission to hospital, he was quite unable to walk; elsewhere motor power was unimpaired. Sensation was considerably blunted over the lower extremities and the transmission of impulses seemed delayed, but complete anæsthesia was nowhere present, and temperature changes were correctly, though slowly, recognized. The knee-jerks were grossly exaggerated, ankle-clonus slightly present; superficial reflexes of lower limbs also exaggerated; reflexes of upper trunk and limbs natural. Urine constantly dribbled away without his knowledge, the urine itself being healthy. There was obstinate constipation, the bowels not having been open for ten days. The cranial nerves were unaffected, except for possibly slight nystagmus, and the pupils were rather sluggish in reacting to light. Under iodide of potassium, pushed freely, the patient soon showed signs of improvement; control over the bladder and rectum was now very fair, and he was able to walk by pushing a chair in front of him. The diagnosis was made comparatively easy by the "random" nature of the symptoms, which did not correspond *in toto* to any known system lesion of the cord, and yet obviously corresponded to a lesion of all the systems in part; and, secondly, there was the admitted history of a recent attack of syphilis. In point of time the onset corresponded well with a very late secondary stage of the disease, and the wide horizontal spread of the trouble indicated what should rather be expected at that period,—namely, a diffuse infiltration of the cord with small cells (granulomatous in nature). Syphilis, as was known, might affect organs in

one of two primary ways,—either by local concentrated growth of a granuloma or by a diffuse infiltration of the organ with cells of a similar nature. Obviously either the blood-vessels of the organ or its parenchymatous cells might be the chief sufferers. Dr. Smith accepted the diffuse infiltration view on the following grounds: (1) the onset of the illness about fifteen to eighteen months after the primary sore; (2) the ingravescent character of the symptoms; (3) the wide diffusion in horizontal area combined with a moderately-rapid, not chronic, development of implication of nerve-structures; and (4) the rapidity of recovery under treatment, pointing to no great severity or permanency of lesion.

Tabes Dorsalis without Ataxia.—Dr. McDonnell showed a man, aged 54, the subject of tabes dorsalis, who presented no ataxia. His father was still alive, aged 74, and suffered from paralysis agitans. He served as a soldier; when 20 years of age he had a chancre, which was fourteen days healing; it was not treated. Either before or after this chancre he had symmetrical suppurating buboes of the groins, which healed in two months. No secondary symptoms. At 51½ years of age his sight became cloudy at the temporal side to the left eye first. Six weeks later the following is the report from Moorfields: "Can count fingers at twelve inches with both eyes. Discs white with a general grayish tinge; vessels not obviously shrunken. No signs of old inflammation. Disc-outlines sharp; surface cupped. Iris reacts to light and well to accommodation. Knee-jerks diminished slightly, certainly less on left than right side. Ten grains (0.65 gramme) of potassium iodide t. d. administered." At 53 he was completely blind. Present condition: Pupils unequal, large, do not contract in response to light-stimulus; to attempted near vision there is some contraction of iris, more distinctly of right than left. Nystagmus is present and some strabismus. Tactile, thermal, and pain sense present in feet, and touch localized correctly. Sense of position of feet and legs present. No girdle pain. Until February, 1894, organic reflexes were normal; but now there is occasional involuntary passing of urine and fæces. There is a presystolic bruit at apex and systolic heard over subclaviary arteries. There is no inco-ordination. The knee-jerk is absent on account of some lesion on sensory side, since both vasti and rectus on both sides respond to faradic current readily, and probably due to sensory muscle-nerves, which have been demonstrated by Prof. C. S. Sherrington.—*British Medical Journal*, December 8, 1894.

UNITED STATES.

Mississippi Valley Medical Association.

Enlargement of the Heart without Valvular Disease.—Dr. Robert H. Babcock, of Chicago, stated that he had found this form of cardiac disease more common than was generally supposed, and that he had met with it most frequently in broad-chested men. He recommended the use of stimulants, but the avoidance of digitalis. When this drug was used he preferred an infusion.

Oxygen as a Heart Tonic.—W. T. BAIRD, of Dallas, Texas, gave clinical histories showing the striking benefit to be derived from the use of oxygen as an inhalation in several forms of disease, and especially in pneumonia. His position was sustained by all the members taking part in the discussion, one of them, who advocated the extemporaneous preparation of oxygen, citing the case of a child who had inhaled about four hundred and eighty gallons of the gas in about seventy-two hours. So decided had been the relief in this case that the boy would awake himself now and then and apply the tube to his face.

Malarial Fever a Water-borne Disease.—DR. WILLIAM H. DALY, of Pittsburgh, maintained this theory of the origin of malaria, believing that the ingestion of water by the mouth would account for almost every case, to the exclusion of the theory of aërial infection. Those who believed in the paramount importance of air as a vehicle for the plasmodium inculcated the avoidance of exposure to the night-air of malarious districts; but how could one shut out the night-air? Did any one imagine that by closing his windows he secured for himself an atmosphere differing in any respect, save that of temperature, from the outer air? To a great extent Dr. Daly's observations had been made upon himself and upon several fellow-members of a sportsmen's club who sought the marshes for duck-shooting every year or oftener, for twenty years or more. During the early years of that period Dr. Daly and his companions, conforming to the prevalent opinion, had braved the night-air of the marshes relying on the free use of quinine, but had drank the marsh-water, unmindful of the possibility of its exerting any morbific influence. The quinine had proved only a partial and unsatisfactory safeguard. It had then occurred to the author that it would be well to try avoidance of the marsh-water for drinking purposes. He and his fellow-sportsmen agreed to pursue this course, and found that they could expose themselves freely to the night-air of the marshes with impunity and without the aid of quinine. The author extolled the value of Laveran's investigations of the cause of malarial disease, and urged their more general teaching in the schools.

DR. HUGHES suggested that the noxious element in night-air might reside in the watery vapor it contained. DR. THOMAS HUNT STUCKY, of Louisville, thought this doubtful.

DR. HORTON, of Midland, Texas, referred to Salisbury's early isolation of a germ considered by him to be productive of malarial disease, and to his experimental conveyance of such disease with that germ, thus anticipating Laveran's work.

DR. MOYER related an experience, on a large scale, that had been strikingly the reverse of what Dr. Daly and his hunting companions had encountered, tending to show the innocuousness of swamp-water and the pathogenic effect of night-air in paludal regions.

Intestinal Indigestion.—DR. A. P. BUCHMAN, of Fort Wayne, Ind., gave an outline of the physiology of intestinal digestion and of its bearing on dietetics, and drew a graphic picture of the many serious diseases that had its continued derangement for their starting-point.

DR. STUCKY spoke of the practicability of tracing intestinal disease to its precise situation in the digestive tract by observing the character of the stools, and dwelt upon the good effects of systematic diet and exercise, together with the use of strychnine, in improving the tone of the muscular coat of the intestines; also of the great advantage to be gained by antiseptic flushing of the large intestine to rid it of clogging and poisonous material. —*New York Medical Journal*, December 1, 1894.

Selections from Reports of Members of the Annual's Staff of Correspondents.

Poland.

DR. J. DRZEWIECKI,
Redaktor Korespondent z działu polskiej literatury tyczącej się: Medycyny ogólnej i lecznictwa; pediatryi; akuszerzyi; ginekologii; laryngologii; otologii; hygieny; demografii; medycyny sądowej; histologii; patologii; bakteryjologii; anatomii; fizjologii.

Wszystkie pisma lekarskie, dzieła, rosprawy, monografije, itd., w języku polskim wydane, a tyczące się przedmiotów powyższych, winny być nadsyłane pod adresem

DRA. DRZEWIECKIEGO,
87, Krakowskie Przedmieście,
Warszawa,
Królestwo Polskie.

Physiological Action of Ephedra Vulgaris.—E. T. GRACHE has made a number of experiments on animals with this drug in the laboratory of Professor Dogel, of Kazan. Ephedra vulgaris is a popular remedy in Poland and Russia in many diseases, and from it are obtained ephedrine and pseudo-ephedrine. The action of these alkaloids, as well as a decoction of the plant itself, was studied, and the conclusions summed up as follows: Small quantities introduced into the stomach or veins, or under the skin, cause slight temporary increase of blood-pressure, with decrease in number of heart-beats and increase in their force. Larger quantities cause a decrease of blood-pressure, from relaxation of the vessel-walls. Distinct arhythmia occurs from irritation of the nerves and muscles of the heart. The functions of the vagi are paralyzed, the action of ephedra on the smooth muscles of the heart causing dilatation of the pupils, from increased action of the sympathetic nerves and diminished action of the oculo-motor nerve, and possibly paralysis of the muscle-apparatus itself. In acute as well as chronic articular rheumatism the drug is inferior to the salicylates.—*Medycyna*, Nos. 36, 37, and 38, 1894.

Round Ulcer of the Vagina.—WLODZIMICRZ SKOWRONSKI describes a case of perforating ulcer of the anterior wall of the vagina in a multipara 37 years of age. It was half a centimetre in diameter, rough, with granulating detritus, gray in color, and bleeding on touch. The ulcer was extirpated and the wound closed with silver-wire sutures. The patient, who was anæmic, improved in health. Microscopical examination showed an absence of mucous membrane, the submucous layer being partly intact. The vessels in the ulcer had coalesced and their walls were thickened. The prognosis in such cases is regarded as unfavorable by the author, on account of the probable recurrence. Should the ulcer extend to any depth it is likely to

cause fistulæ or fatal hæmorrhage. The treatment of neglected cases is difficult and unsatisfactory. The cause, according to Zahn and Browicz, is local atrophy of the blood-vessels.—*Przeglad Lekarski*, No. 37, 1894.

A Rare Case of Twins.—EPSZTEIN describes a case of twins in which one child was born six days before the other. He was called to attend the woman the third day after the delivery of the first child. As there was no special indication for interference, he decided to wait, the surroundings of the patient being such that infection might have followed any operation, while hæmorrhage might also have resulted. Labor proceeded naturally, and both the children lived.—*Nowiny Lekarskie*, No. 4, 1894.

Ether Narcosis.—LEON SZUMAN has used ether as an anæsthetic in eighty-one cases, and has come to the conclusion that, while it cannot entirely replace chloroform, it is an excellent anæsthetic. It is contra-indicated in bronchitis, being extremely irritating to the bronchial tubes and liable to cause relapses of the affection. He used it in several cases of cœliotomy, as he observed that the pulse did not fall as much as under chloroform. Experience is necessary for its successful employment, and the danger of using it near artificial light or in connection with the galvanocautery is insisted on.—*Gazeta Lekarska*, No. 37, 1894.

Sweden.

DR. F. EKLUND,
Brefväxlande Medarbetare
för den
SVENSK MEDICINSK LITTERATUR.

Af alla i Sverge utkommande medicinska tidskrifter, bocker, afhandligar, monographier a. s. v. torde ett exemplar benäget öfversändas till

DR. ABRAHAM FREDRIK EKLUND,
Sibyllegatan, 3 A,
Stockholm.

A Case of Tetany.—H. KÖSTER reports an interesting instance of this disease in a baker, aged 21 years, whose mother and sister were subject to attacks of cramp. Six months before the patient was seen by the author painful contractions had set in without any known cause, being more aggravated when the air was chilly and less in warm weather. These contractions gradually increased in intensity until, on the patient's entrance into hospital, they affected the muscles of the eyes, arms, chest, and especially the abdomen and legs. There was difficulty in swallowing and retention of urine. The cramp was at times tonic, at others clonic, but usually the patient could overcome them by an effort of the will. The muscles were tender, but not atrophied or paretic. The fists were clenched during an attack; Trousseau's and Erb's symptoms were pronounced; there was intense reaction of the muscles to mechanical irritation, but the facial symptom of Chvostek was absent, as was also the patellar reflex. The other reflexes were present and sensibility was normal. The post-mortem examination showed primary atrophy of the kidney and circumscribed hæmorrhages in the anterior portion of the cauda equina and about the nerve-roots from the third to the fifth nerves in the neck on both sides. There was also hæmorrhage and hyperæmia of the sheath of the ischiatic nerve and the surrounding connective tissue in the left leg. The nerve-

trunks, spinal cord, and brain were macroscopically normal.—*Göteborg's Läkaresällskaps Förhandlingar*, p. 145, 1894.

Arterio-Venous Aneurisms.—T. A. HEDLUND describes the case of a laborer who cut himself on the inner side of the right thigh for a distance of about three inches. There was profuse hæmorrhage and the man became unconscious. The thigh was tied with a towel and gangrene set in. Two weeks after the accident an irregular, movable swelling appeared on the inner surface of the thigh, about eight centimetres in length. This was extirpated and the patient recovered. The author collects eighteen similar cases from literature, in which complete extirpation of the aneurism was successfully performed, no gangrene or secondary hæmorrhage following the operation. He is of the opinion that when immediate treatment is indicated direct and indirect digital compression should be combined. In cases in process of development four double ligatures should be employed, both the lacerated veins as well as the arteries being tied. The same method is recommended in cases where the aneurismal sac is fully developed, on the ground that by the use of these ligatures secondary accidents are prevented, the establishment of the collateral circulation being made easier.

Uratic Deposits and Albuminuria in the Newborn.—CHARLES FLENSBURG, in a study of this subject, states that immediately after birth the urine is charged with urates in considerable quantity, arising from a secretion of the epithelial cells of the convoluted tubules during fœtal life, which with the hyaline elements may be regarded as the primary origin of uratic deposits. According to Horbaczewski, the normal leucocytosis of the newborn is the cause of the increased amount of uric acid in the urine. Up to a certain point, at least, this acid, like other acids artificially introduced into the body, causes an increased production of ammonia, and the two in combination form the urate of ammonia, which is easily precipitated and becomes incrusted upon the hyaline elements.—*Nordiskt medicinskt Arkiv*, xxvi, 2, 1894.

Clinical Notes.

Antidiphtheritic Serum.—The treatment of diphtheria by antitoxin continues to occupy the attention of all professional minds, and experiments are being made with it in every country. The meeting of the Medical Society of Greifswald, of November 9th, was entirely devoted to a discussion of the subject, and BÖRGER gave his results in 30 cases, in 5 of which tracheotomy had been performed. There were but two deaths, or a mortality of 7 per cent. In former years, with other methods of treatment, the death-rate was 14.5 per cent. The serum is therefore manifestly more beneficial than other remedies. As to the effect of the injections, Dr. Börger noted an amelioration of the local condition within from twelve to twenty-four hours, with lowering of the temperature in from two to four days; albuminuria was somewhat frequent, but only transitory.

Dr. Löffler insisted on the necessity of local treatment in connection with the serum. He had found wonderfully efficacious a solution consisting of menthol, 10 parts; toluol, 36 parts; alcohol, 60 parts; perchloride of iron, 4 parts.

Dr. Struebing had found this solution valuable not only in angina due to pseudo-diphtheria and various other microbes, but also in true diphtheritic angina, when treatment was instituted at the onset of the disease.

Dr. Beumer reported two cases showing the prophylactic action of the serum. In one family, in which five children were suffering from diphtheria, a sixth child was vaccinated with antitoxin and remained free from the disease, although continually in contact with his sick brothers. Three pupils in a boarding-school were attacked with diphtheria; the balance of the pupils—fourteen in all—were vaccinated and remained free from the affection.

Dr. Peiper related a case of diphtheria treated by the serum, in which albuminuria appeared eight days after the injection and five days after the child had recovered.

Dr. Abel gave the result of his researches upon the antitoxic power of the blood of convalescent diphtheritic patients. The bactericidal power appeared only on the eighth or tenth day after recovery and persisted for several months. The serum of individuals who had never had the disease possessed also, in certain cases, an evident bactericidal power.

At the Medical Society of Königsberg, on November 12th, Dr. Hilber communicated the results of experiments made at the clinic of the faculty. Eleven cases (two with symptoms of croup) were treated with the serum, and all recovered. The mortality at Königsberg from diphtheria is ordinarily 22 or 23 per cent.

At the Pediatric Society of Moscow, November 20th, M. Polieugtoff reported nine cases of diphtheria, two of which were treated with Aronson's serum and seven with Roux's serum, only one case proving fatal.

Professor Filatoff added a tenth case, cured by Behring's serum. In analyzing the cases observed at his clinic, this speaker concluded that small children support Roux's serum very well, even in large doses. The complications observed are somewhat severe pain at the point of inoculation and temporary albuminuria. If treatment be begun before forty-eight hours have elapsed, the later complications of diphtheria do not appear.

Cnyrim (*Deut. med. Woch.*, No. 48, 1894) observed two cases in which, thirty-six hours after the injection and twelve hours after complete defervescence, a generalized nettle-rash appeared, with fever and severe rheumatic and neuralgic pains. The complication disappeared within forty-eight hours.

M. Mendel (*Berliner klin. Woch.*, No. 48, 1894) describes a case in which a generalized hæmorrhagic exanthema appeared eight days after the injection, but disappeared rapidly upon rest in bed.

Lees, Christie, and Phillips each report a case cured by the use of the serum, and Simpson three cases with two deaths.—*British Medical Journal*, November 10, 1894.

The communication of Dr. Hansemann to the Berlin Medical Society

is a veritable impeachment of serum-therapy, and one in which there is an evident and premeditated intention of ignoring the most elementary facts. The author begins by declaring that the bacillus of Löffler is not the diphtheria bacillus in the clinical sense of the word. It is absent in 30 per cent. of the cases, is always associated with streptococci and staphylococci, and is absent in certain clearly diphtheritic affections (fibrinous rhinitis, conjunctivitis, etc.). Subcutaneous injections into animals provokes only a simple œdema. In the throats of animals it does not cause diphtheria when the mucous membrane is healthy. Animals brought in contact with diphtheritic patients do not contract diphtheria. His conclusion is that the bacillus of Löffler is incapable of producing the diphtheria of Bretonneau (?). He seems to ignore the classic researches of Roux and Yersin, who, by the discovery of toxins, determined the specific nature of Löffler's bacillus.

It is claimed, states Dr. Hansemann, (1) that the cure is effected by immunization through the infection itself; (2) that immunization is effected through the antitoxins. According to him, the first hypothesis has yet to be proven (which is absolutely true); as to the second, no one has yet seen the antitoxins (which is partly false). Finally, he maintains that the serum does not immunize, does not cure, and is directly injurious on account of the nephritis which it provokes.

What is most curious about this article of Dr. Hansemann is that behind its author hides a great scientific and medical authority of Germany (Professor Virchow).—*La Tribune Médicale*, December 12, 1894.

Five cases were treated by Dr. William M. Welch, at the Municipal Hospital in Philadelphia, with Behring's serum, death occurring in two of the cases. Dr. D. Braden Kyle, who made the bacteriological examination, found the Klebs-Löffler bacillus present in two of the patients' throats on the twenty-first day after admission to hospital. Dr. A. Campbell White gave a report on a series of cases treated at the Willard Parker Hospital, New York. In 14 of the 20 cases the disease involved the larynx, the patients being, with one exception, under 5 years of age. He stated that the ordinary mortality in our hospitals, in this class of cases, was 40 or 50 per cent., and that this had been reduced to 25 per cent. in the cases treated with antitoxin.—*Medical News*, November 17 and December 1, 1894.

Dr. P. H. Mules, of Bowdon, England, treated four cases, all in the upper classes of society, surrounded with every care, skilled nursing, and modern appliances. The first recovered without antitoxin, the second died with antitoxin, the third died from paralysis without antitoxin, and the fourth in the early stage with antitoxin. He used Aronson's serum.—*Lancet*, December 8, 1894.

The Increase of Insanity in Ireland.—In discussing the alleged increase of insanity in Ireland, Thomas Drapes, of Enniscorthy, states that there is one peculiarity about Ireland which has been repeatedly noted, but not explained, namely, that while in other countries insanity has increased along with and in a higher ratio than an increasing population, in Ireland alone it increases continuously with a continuously decreasing population; and

what appears to be an almost necessary consequence, the proportionate rate of increase in Ireland is far beyond what exists elsewhere. A careful investigation of the comparative statistics of England and Ireland, however, shows that while there is an undoubted increase in occurring insanity, as indicated by the records of first admissions, by far the larger part of the apparent increase in insanity generally is due to accumulation, and that the seeming preponderance of insanity in Ireland, as compared with England, is fictitious, and depends entirely upon the greater amount of accumulation in Ireland, occasioned by the lower death-rate in that country and (possibly) the lower rate of discharge of the unrecovered. The author regards emigration as one of the causes, though he believes its effects to have been overestimated.

D. Hack Tuke, in a paper on the same subject, alludes to emigration as an important factor, from the influence exerted upon the feebler portion of the community, owing to the worry and increased responsibility thrown upon them by the removal of a great mass of the healthiest and strongest persons. Further, the unhappy circumstances of the population, deprived to a large extent of the bread-winners of families, has been aggravated by marriages amongst this enfeebled class of the community and the consequent hereditary transmission of feeble minds, a serious degeneration of the race following.

Oscar Woods, in the discussion, confirmed the observation of Drapes as to the rarity of general paralysis among the Irish, this being one of the causes of the low death-rate. Of 1200 patients in the Cork Asylum, he had only 4 suffering from general paralysis. In 1892 but 21 deaths in Irish asylums out of a total of 995 were assigned to this cause,—hardly more than 2 per cent. In England, on the other hand, the mortality from this disease is very high, accounting for from 18 to 20 per cent. of the total deaths in asylums.—*Journal of Mental Science*, October, 1894.

The Dyspepsia of Strumous Children.—W. Soltau Fenwick, in a clinical lecture upon this subject at the Evelina Hospital for Sick Children, London, states that mild cases of strumous dyspepsia are very common and usually escape notice, but that the more severe forms immediately claim attention. Of 200 cases of disease in children during the past year in his service, 32 suffered from the disorder. In the majority of cases there is a strong family history of tuberculosis, and usually some of the brothers or sisters of the patient suffer from scrofula. The disease usually appears about the age of five years, and in addition to the general tuberculous aspect there is usually some local manifestation, such as chronic enlargement of the cervical glands, hypertrophy of the tonsils, or phlyctenular ulcers of the cornea. Anæmia is always a noticeable feature, while pain in the abdomen is the most constant and characteristic symptom. It comes on suddenly, lasting from a few minutes to several hours, the face being flushed with free perspiration, although at times great pallor is present. The pain is described as a griping or twisting sensation in the region of the transverse colon, though occasionally the right iliac region or the hypogastrium is indicated as the chief site of suffering. Constipation, exhaustion

from want of food, and excessive mental or physical fatigue are the principal factors which seem to excite an attack.

As a rule the appetite is poor and extremely capricious, and the patient exhibits an intense dislike to most forms of fat, especially that of mutton, beef, and pork. Bacon-fat, on the other hand, is often agreeable, and milk, butter, and codliver-oil never give rise to any unpleasant symptoms. Occasionally dislike is expressed for the carbohydrates, and saccharine materials are found to occasion flatulence, acidity, or nausea. Many of the patients also develop a special liking for certain articles which are usually regarded as the reverse of digestible or nourishing, vinegar and lemons enjoying an extreme degree of popularity. Thirst always constitutes a prominent symptom, and is chiefly complained of during the night or early morning.

Although the ordinary symptoms of gastric disease, such as nausea, acidity, and flatulence, are usually absent in these cases, it occasionally happens that a sudden change in the atmospheric conditions or some slight indiscretion in diet will induce an attack of subacute gastric catarrh. Under these circumstances the patient awakes in the morning with headache, and complains of nausea and a foul taste in the mouth. The appetite is in abeyance, but thirst is excessive. The face appears pale and puffy, and dark lines make their appearance beneath the eyes. The breath is sour and the dorsum of the tongue covered with a thick white fur, while the tip and edges are of a vivid red color. The pulse is slightly quickened, and the temperature raised a degree or so above the normal. Nausea is a persistent symptom, and retching or vomiting follows every attempt to partake of food. As a rule diarrhœa complicates the gastric disorder, but occasionally constipation is observed. These catarrhal attacks last from two to five days, and are apt to recur from time to time.

After the age of puberty the various symptoms of the complaint generally subside, but the patient may still be subject to occasional attacks of gastric catarrh. In some instances, however, the disease undergoes a kind of evolution, and the stomach, rather than the intestine, eventually becomes the chief seat of the disorder. Dr. Fenwick regards the affection as essentially a neurosis of the intestinal tract, associated with extreme difficulty of digestion and absorption of neutral fats, both conditions being dependent upon the strumous dyscrasia.—*Clinical Journal*, October 24, 1894.

Cæsarian Section in a Case of Vaginal Contraction.—Dr. Alfred Bland Tucker, of New York, reports the following interesting case: A woman aged 28 was twice married, the first time at the age of 15 years. She had menstruated at the age of 11 years, the flow being regular, but scanty and accompanied with considerable pain. Her first husband had found intercourse impossible, and she consulted a physician, who operated upon her for atresia or imperfect development of the vagina,—the patient was unable to say which. He performed a second operation a few months later, afterward dilating the vagina with glass tubes for a period of ten days, when she removed to the West. The vagina again became contracted, but treatment was not regularly instituted. The husband died and the

patient married again. When she came under the care of Dr. Tucker she was in the sixth month of pregnancy, and the vagina was so small that the finger could with difficulty be introduced. When the first stage of labor set in the pelvic measurements were as follow: Superior spine of ilium to opposite superior spine, 8½ inches; tip of coccyx to pubic bone, 3 inches; external conjugate, 5 inches; trochanters, 11 inches; diagonal conjugate, 4 inches; from tuberosity of ischium to same point on opposite side, scarcely 2 inches.

The patient was sent to hospital and Cæsarian section performed by Dr. Tucker, who made the usual incision, finding the placenta immediately beneath. He did not detach it, but put his hand through, when the membranes ruptured and the child, placenta, and water came out with sufficient force to throw the child over the abdominal walls of the mother. Three rows of sutures were made in the uterus with silk and the abdominal wall closed with one row of silk-worm sutures. Symptoms of intestinal obstruction appeared within thirty-six hours, but were successfully controlled by the use of the stomach-tube, about four quarts of water being used to wash out the stomach. The child weighed eight pounds and breathed a few times, but could not be resuscitated. Death was evidently due to unavoidable loss of blood in going through the placenta. The mother's recovery was uninterrupted.

The Significance of Pain.—In a lecture at the Hôpital de la Charité, PROFESSOR POTAIN spoke of the value of pain in the diagnosis of disease, and stated that its absence usually made the prognosis more sombre, latent affections being grave because they develop freely without any warning to the patient. It is because of the absence of pain that many affections have remained so long obscure and have caused great ravages, such as endocarditis, chronic nephritis, and aortitis. Certain diseases, usually painful, may sometimes exist without this symptom; in walking typhoid fever the pain is so slight that the patient can carry on his ordinary avocation until intestinal perforation occurs, causing rapid death. In pleurisy the pain, sometimes so great, may be absent, but the disease is none the less serious on that account. Cases of angina pectoris in which there is no pain are the most dangerous.

Certain diseases consist only of pain, such as gastralgia and enteralgia; in others pain is the predominating symptom. It should, therefore, be studied with the greatest care, and its characteristics fully determined. Its intensity is what naturally strikes the patient, but this is not at all proportionate to its cause, and depends upon individual conditions. It is well known that certain races are but slightly sensitive to pain, and that education plays a great part in this sensitiveness. A reliable physician states that there is at Chantilly a colony of English jockeys who, accustomed to horseback-riding, are liable to numerous fractures, but seem to feel only slightly the pain caused by them; while their wives, with but rare exceptions, never utter a cry during delivery.

The intensity of pain is of value to the physician only when it is excessive; for instance, an intensely painful spot in the side may indicate gan-

grenous pleurisy; the appearance of peritoneal pain in typhoid fever may often indicate perforation of the intestine. The seat of the pain has but little relation to the disease; thus the painful point in pleurisy is nearly always the same, no matter what may be the precise location of the inflammation. The only exception to this is the pleuritic pain of tuberculosis. Dorsal and substernal pain ordinarily indicates an affection of the œsophagus, but to make an exact diagnosis it is necessary to use the sound. Gastric pain indicates the location of the disease as a general rule, and the patients are not deceived when they complain of pain in the stomach. Disturbance of the biliary passages is generally marked by pain in the right hypochondrium, and colitis sometimes causes terrible pain beneath the umbilicus from one hypochondrium to the other. Nephritic colic causes pain along the corresponding ureter. Vesical pain is easily recognized because of the tenesmus which accompanies it. There are pains the seat of which is pathognomonic, such as angina pectoris, where it is prethoracic and radiates into the left arm and sometimes into both arms. To this rule, however, there are many exceptions. Hepatic colic may cause pain only in the epigastrium and simulate gastralgia, while epigastric pain is often related to alterations of the solar plexus, such as that due to aneurism of the abdominal aorta.

Reflex pain is also an important aid in diagnosis. It is necessary to bear in mind, in this connection, the dorsal pain in gastric affections; the scapulalgia of hepatic colic; the pain in the posterior portion of the deltoid region in diseases of the liver; the irradiations of nephritic colic into the testicles and thighs; the brachial and cervical pains of angina pectoris; the costo-xiphoidal pain of diaphragmatic pleurisy and pericarditis. Rectal pain often extends to the thighs, especially in elderly, constipated men, and such pain should always call for a rectal examination. In affections of the colon pain is frequently felt in the præcordial region. Chronic colitis causes the arrest of the fæcal matter at the bend of the intestine between the transverse and descending colon, and the præcordial pain arising from this is a source of frequent errors in diagnosis. Of one hundred persons complaining of heart disease, about seventy have some affection of the colon. Ovaritis often gives rise to intercostal pain, and when the cause of a persistent neuralgia of this region in a woman cannot be found it is well to consider the possibility of ovarian trouble.

Pain upon pressure gives more precise information to the physician than any other. When this exists at the points of emergence of nerve-branches only, it indicates a neuralgia; when it exists along the entire course of the nerve, the case is one of neuritis. The absence of pain upon pressure in cases of spontaneous pain indicates its reflex nature.—*L'Union Médicale*, November 22, 1894.

Surgical Treatment of Hydrocephalus.—Dr. Bilhaut, of Paris, in a paper before the French Surgical Association, expressed the opinion that the surgeon commits a mistake in resorting to operation for the cure of this disease. The etiology, the malformations present, and the anatomo-pathological disorders which attend it, all attest the truth of this assertion. The

only cases in which operation would likely be successful are those in which there is no risk, and in which the classical medical treatment would also bring about good results. When hydrocephalus is the symptom of a material lesion, such as meningo-encephalitis, tumor, or degeneration of the cerebellum, surgical treatment is illogical, as it does not attack the origin of the trouble. Statistics of the cases in which operation has been attempted go to show that the method should be abandoned.—*La France Médicale*, December 7, 1894.

Antipyrin.—T. McCall Anderson has come to the conclusion that none of the coal-tar derivatives recently introduced can compare in value with antipyrin, either as to certainty of action or as to the wide field of usefulness. The initial dose should not exceed 10 or 15 grains (0.65 or 1 gramme), and the cases should always be carefully watched, the amount of the drug being slowly and cautiously increased. He has found that it may be given with safety in large doses, even to children, if proper care be observed. In such large doses, the results which it yields are often surprising, and in chorea it is the only medicine from which cures may be confidently expected. The author reports cases in his own practice illustrating its good effects, and showing that it is not the dangerous drug that some authors have led us to suppose.—*British Medical Journal*, December 1, 1894.

Gallobromol (Dibromogallic Acid).—This new drug has been carefully studied during the past year by Professor Lépine, of Lyons, who found it to be an excellent succedaneum of the alkaline bromides, well borne by the patients, even in large amounts. The dosage is the same as the former drugs; 10 to 15 grammes (2½ to 3¾ drachms) daily can be given without inconvenience. Gallobromol consists of fine white needles, soluble in cold water, more easily soluble in hot water, alcohol, and ether. The solution in ordinary water, which is always alkaline, turns to a reddish color, and distilled water should always be used to dissolve it.—*Journal de Pharmacie et de Chimie*, November, 1894.

Renal Sarcoma in a Child.—Bérard, of Lyons, describes a case of sarcoma of the kidney weighing about 3 kilogrammes (6½ pounds) developing within four or five months in a child 5 years of age, without causing hæmaturia, varicocele, or any urinary trouble. The patient died from extreme emaciation, before any surgical intervention could be attempted. The parents stated that some six months previously the child had fallen, striking violently on the lumbar region. Since that time he had failed in health, while the abdomen increased in size. At the post-mortem examination, it was found that there were also metastatic deposits in the liver and peritoneum, showing that surgical treatment would have been of little value, owing to the rapid generalization of the tumor.—*Lyon Médical*, November 11, 1894.

Cantharidinate of Potassium in Phthisis.—Petteruti treated several cases of phthisis with this drug three years ago, when it was first recommended by Liebreich, but the results at the time appeared to him to be unsatisfactory. He has had an opportunity to examine three of these pa-

tients recently, however, and finds that two of them are completely cured, and a third so much better that the case simulates a recovery. An improvement lasting for three years appears to the author to be more than the temporary improvement which sometimes occurs in phthisis, and he deems the cases worthy the attention of the profession.—*Il Policlinico*, November 1, 1894.

The Diagnosis of Tubercular Joint Disease.—Mr. A. G. Miller, of the Edinburgh Royal Infirmary, gathers, from the statistics of that hospital, that the proportion of tubercular to all other joint affections of the extremities is from three-fourths to four-fifths. The leading and most reliable characteristics of the disease are: the mode of onset,—the history of a slight injury which was not treated and forgotten, or treated in such a way as not to bring about recovery; the appearance of the joint,—pale, ovoid, and smooth, with perhaps some unusually distinct superficial veins and a number of long, silky hairs (if the patient be old enough); slight, but distinct elevation of temperature as compared with the surrounding parts; absence of pain except on movement, and limitation of movement. The absence of pain is peculiarly characteristic of tubercular disease, and is due to fixation of the joint and to the slight degree of inflammation present, the latter being subacute and chronic. At the same time it is extensive, and usually involves, sooner or later, all the tissues of the joint,—bone, cartilage, periosteum, synovial membrane, ligaments. The condition is arthritis,—that is, an affection of the joint as a whole,—and not merely a synovitis, as it is sometimes designated. This peculiarity explains the characteristic pain on movement, for with movement one or more of these structures is hurt and pain results. Another symptom especially characteristic of tubercular joint disease is atrophy. This affects the whole limb to a greater or less degree; it is greater and more rapid than can be explained by mere want of use; it is more marked than in any other joint affection; it especially affects certain muscles and groups of muscles, each joint having its peculiarities, which are very constant. In the hip, the glutei are affected; in the knee, the quadriceps extensor; in the ankle, the extensors; in the shoulder, the scapular muscles; in the elbow, the triceps and biceps; in the wrist, the muscles arising from the internal condyle of the humerus.

The differential diagnosis of the disease from other affections for which it is sometimes mistaken may be elucidated by the following tables:—

THE STRUMOUS JOINT.	THE HÆMOPHILIC JOINT.
1. Slight injury, or none.	1. Injury, often slight.
2. Joint pale, ovoid, slightly warm, boggy (seldom fluctuating; patella fixed in knee-case), and synovial membrane thickened (œdematous).	2. Joint pale or slightly discolored, rounded in outline (shape that of simple synovitis), warm, boggy, or fluctuating (in case of knee-patella, movable).
3. Limb fixed, movement painful, and resisted by muscles.	3. No fixation or pain on movement if performed gently.
4. Marked muscular atrophy, especially of extensors.	4. Muscular atrophy not a symptom.

5. Presence of tubercular affections elsewhere.
6. History of tubercle in family.
7. Patient delicate-looking.
8. Rest will not bring about a cure in a week or two.

5. Marks of ecchymosis.
6. History of hæmophilia among males of family, transmitted through females. History of former bleedings from cuts, epistaxis, etc.
7. Patient delicate-looking.
8. Rest will cure in a week or two.

THE TUBERCULAR JOINT.

1. Joint pale, ovoid, hot, boggy; large veins, hairs, etc.
2. Joint fixed; movement painful.
3. Pain not a special symptom.
4. Marked muscular atrophy, especially of extensors.
5. History of tubercle, and perhaps presence of tubercle elsewhere.
6. Disease progressive, or else improving under treatment.
7. Under chloroform distinct evidence of disease.

THE HYSTERICAL JOINT.

1. Joint enlarged; nothing definite to be made out.
2. Joint fixed; movement resisted.
3. Hyperæsthesia; pain at varying points.
4. Limb may be smaller, but there will be subcutaneous fat.
5. History of nervous complaints. Evidence of hysteria; ovaries sensitive, etc.
6. Disease stationary, and no improvement from local remedies.
7. Under chloroform all symptoms disappear.

WHITE SWELLING.

1. History of slight injury.
2. Joint pale, ovoid, warm, boggy; enlarged veins, hairs (if suppuration, fluctuation, pointing).
3. Limb fixed; movement painful.
4. Marked muscular atrophy, especially of extensors.
5. Tubercular history and tubercle elsewhere.
6. Comparatively slow growth.
7. Slight rise of temperature, which is irregular.

SARCOMA.

1. History of injury.
2. Swelling near joint; smooth, rounded, warm, elastic, large veins; may fluctuate at parts.
3. Healthy joint can be made out.
4. Muscular atrophy general.
5. No tubercular history; patient healthy till tumor began to grow.
6. Comparatively rapid growth.
7. If rise of temperature, it is steady.
8. Growth commences at one side; may pulsate.

STRUMOUS ARTHRITIS.

1. Slight injury or none.
2. Joint pale, ovoid in outline, slightly warm, boggy, synovial membrane œdematous.
3. Limb fixed by muscular spasm.
4. Marked muscular atrophy, especially of extensors.

CHRONIC TRAUMATIC SYNOVITIS.

1. Pretty severe injury.
2. Joint pale, swelling shape of synovial membrane, fluctuation, synovial membrane thickened.
3. Joint movable, unless adhesions, when movement arrested abruptly at certain point.
4. Muscular atrophy slight and general, not special.

5. Tubercular history and tubercle elsewhere.	5. No tubercular history or manifestation.
6. Slight rise of temperature, of irregular type.	6. Temperature normal.

STRUMOUS ARTHRITIS.	SYPHILITIC SYNOVITIS.
1. Slight injury.	1. Came on slowly.
2. Joint ovoid and boggy.	2. Joint shape of synovial membrane; fluctuating.
3. Rigid and painful on movement.	3. Painless, movable, but weak.
4. Atrophy marked and special.	4. Atrophy slight and general.
5. May be multiple, but not symmetrical.	5. Sometimes symmetrical.
6. History of tubercle.	6. History of syphilis.
7. Tubercle elsewhere.	7. Traces of syphilis elsewhere.
8. Not materially benefited by mercury and K. I.	8. Benefited by mercury and K. I.
9. Increase of temperature.	9. No increase of temperature.

TUBERCULAR ARTHRITIS.	CHRONIC RHEUMATOID ARTHRITIS.
1. Patient usually young.	1. Patient usually advanced in life.
2. Tubercular history.	2. History of rheumatism or gout, or both.
3. Tubercle elsewhere.	3. Chronic rheumatoid arthritis elsewhere.
4. Joint ovoid and boggy.	4. Ends of bones enlarged; synovial membrane thickened, and containing fluid.
5. Joint fixed; pain on movement.	5. Pain on movement, perhaps grating; joint not fixed.
6. Muscular atrophy, especially of extensors.	6. Muscular atrophy general.
7. Not affected by weather.	7. Affected by weather.
8. Slight rise of temperature, which is irregular.	8. No rise of temperature generally; rather subnormal.

TUBERCULAR ARTHRITIS.	CHRONIC TUBERCULAR EPIPHYSITIS.
1. Joint enlarged, ovoid, boggy, etc.	1. Joint free; swelling above or below joint.
2. Pain not a prominent symptom, only on movement.	2. Pain on pressure on epiphysis; worse at night.
3. Joint fixed, etc.	3. Joint not fixed usually.
4. Atrophy of muscles, etc.	4. Atrophy not so marked and not "special."
5. No special œdema of limb.	5. Limb œdematous below diseased part; slight collection of fluid in joint (symptomatic).
6. Slight rise of temperature, which is irregular.	6. Rise of temperature more marked.

—*Edinburgh Medical Journal*, November, 1894.

Glaucoma with Intra-ocular Hæmorrhages.—Dr. Charles A. Oliver, of Philadelphia, gives the results of a microscopical and clinical study of two cases of glaucoma offering a striking contrast to each other. The first,

a well-cared-for, though dissipated, man of 62 years, suffering from grave nerve disease, suddenly presented a right-sided thrombotic and embolic process in an eye that had evidently been the subject of retinal hæmorrhage, and had shown signs of increased intra-ocular pressure. Each hæmorrhage did not confine itself to the larger lymph-stream channels, but actually forced its way into the interstices of important nerve-structures. The disastrous pressure and probable disintegration of contiguous tissues from the disorganizing and probably irritating blood- and lymph- material soon weakened the structures and rendered them less able to cope with the constantly-increasing vascular disorder. Unable at last to endure the intense neuralgia, which was temporarily relieved by a carefully-performed and uncomplicated iridectomy, it became necessary to remove the entire eye, both for the comfort of the patient and for his safety. Since then, though his health has steadily grown worse, the left eye has, by constant care, been kept in excellent working condition.

The second case was that of an apparently healthy middle-aged man, without any evidence of gross organic lesion or general disturbance of the secretory or excretory system, who in the course of three years developed a comparatively painful blindness of the left eye, with almost complete loss of vision on the neuralgic right side. An acute exacerbation of pain decided him to submit to an iridectomy, which was safely accomplished upon a degenerate and, fortunately, probably but slight vascular tissue, from which there was but little hæmorrhage. Relief was obtained for several months, when another attack followed neglect to continue the use of eserine. The process was again checked by a second operation on the left eye without any complications, care being taken this time to keep the patient's general regimen, diet, etc., under the strictest surveillance. The eye being then quiet and all visible hæmorrhage having been absorbed, the last hope for useful sight was afforded him by the extraction of the cataractous and swollen lens of the right eye. This was accomplished without accident, and central vision brought to a higher acuity than during the entire time that he was seen by the author. This degree of visual power has been held in an eye whose tonus is seldom, if ever, above normal; an eye, however, that too surely is showing the slow, steady, and irregular contraction of the field, as seen in the increasing pathological excavation of simple and chronic glaucoma. The cases show, in Dr. Oliver's opinion, that in some extremely rare cases of glaucoma secondary to slight recurrent attacks of intra-ocular hæmorrhage, especially in young and comparatively sthenic subjects in whom the vascular system is not greatly involved, the organ may be kept for much longer periods than is ordinary in such cases in a condition of usefulness, by appropriate hygienic and general therapeutic measures; care being taken to carry out operative measures whenever there is urgent necessity to relieve intra-ocular pressure by rendering patulous the most important outlets for the intra-ocular fluids.—*International Medical Magazine*, September, 1894.

Bromoform in Whooping-Cough.—S. Grover Burnett has observed a stuporous condition following the administration of the initial dose of

bromoform in whooping-cough, the amount given being 5 drops. On gradually increasing to 8 drops, after a few days the stupor again returned, the paroxysms, which had increased after the first dose, now declined, and an erythema appeared over the entire body, showing that the stupor was dependent on the use of the drug, as well as showing the physiological action of the drug, indicating its full effect. He finds that its immediate use in the disease, 1 drop for each year of the age, gradually increased, with hot-water drink, commencing with the appearance of the first symptom, will limit the attack to two and a half or three weeks. Medication postponed till the "whoop" appears will not greatly shorten the attack, but will lessen the severity and the number of the paroxysms. Interrupted medication of two days will render the paroxysms less controllable than before the discontinuance and prolong the attacks into the fourth and fifth weeks. Improper or non-systematic medication only aggravates the condition of the child.—*Kansas City Medical Record*, September, 1894.

Death following Vaccination.—Reginald Farrar, of Stanford, Eng., records a case of death following vaccination in a child 5 months old, rather small and thin for her age. The vaccination was carefully performed, and a week later there were three vesicles of perfectly-normal aspect. Neither at this nor at any subsequent date was there any inflammatory area around the vesicles; nor did the ulceration at any time spread beyond their limits. Instead, however, of the scabs drying up and separating in the usual time, they persisted unduly, and from the intermixture of clotted blood presented a "limpet-shell" aspect, resembling rupial scabs. When at last they separated the ulceration was found to have penetrated the whole skin, exposing the muscles beneath and leaving holes which looked as if they had been punched out. There was no œdema of the arm, and the skin around the vesicles appeared perfectly healthy throughout.

Seven weeks after vaccination, and about a week after the separation of the scab, the child died, having gradually wasted away. The author considers death to have been due to a constitutional malaise, induced by vaccinia in a poorly-nourished child, and he advises vaccinators to avoid its use in weakly children.—*British Medical Journal*, October 13, 1894.

Laminectomy.—H. C. Wyman, of Detroit, in considering the removal of the vertebral spines and laminæ, states that the vertebral canal may be opened so that the lateral and posterior aspects of the spinal cord can be easily examined by first making an incision through the integument and superficial fascia, four inches long, over the spinous processes nearest to the diseased area of the spinal cord, and cutting away the muscles and tendons from their attachments to the spinous processes and the laminæ. For this purpose it is well to use a strong knife and periosteal elevator, so that the periosteum may be turned back with the tendons and muscles, as it subsequently becomes useful in filling in the boneless area. A pair of strong retractors with teeth are commonly needed to hold back the soft parts, so that the laminæ can be divided with a chisel and bone-forceps. After the laminæ on each side of the spinous process have been cut

through, the latter is caught with a strong forceps and lifted from its bed, exposing the vertebral cavity and the dura mater. A considerable space normally exists between the dura mater and its investing wall of bone. Through an opening made by lifting out the spinous process and lamina of one vertebra, the cord can generally be examined a distance of an inch above and below the opening. It is not often necessary to remove more than the posterior segment of one vertebra. If the chisel and bone-forceps are used cautiously, and no more bone is removed than is necessary to overcome the pathological conditions on which the operation rests, there will be no need of splint or other apparatus to support the spine during the healing of the wound. A gauze-and-cotton dressing should be applied, and changed as often as it becomes soiled. In closing the wound, care should be taken to close the periosteum and muscles over the boneless area with silk sutures. Drainage is rarely needed, as gravity does the work. The impairment of bowels and bladder incident to paraplegia makes the after-treatment and care of laminectomy cases particularly important. Bed-sores are apt to occur if the patient is not lifted from his bed several times daily; and for this purpose a sufficient number of nurses is the most satisfactory means that can be employed. The dribbling urine is apt to get into the bedding and infect the wound, if not carefully removed. The author uses a sterilized catheter, lubricated with freshly-sterilized oil, three times a day, and a rubber or glass urinal in the intervals. A diet containing well-cooked Indian meal helps to keep the bowels in a proper state of solvency.—*New York Medical Journal*, October 6, 1894.

Puerperal Blood-Poisoning and Sewer Emanations.—In discussing this question, Dr. M. Handfield-Jones, Obstetric Physician to St. Mary's Hospital, London, alludes to sewer-gas poisoning as a special source of danger in private obstetric practice, never found nowadays in the lying-in hospital. Some attempts have recently been made to show that these poisons are not so toxic as have been supposed, that men who work in the sewers enjoy very fair health, and that the poor who live in insanitary houses do not suffer to the degree that one might expect. In every case of such poisoning, however, there are two points to be considered: (1) the resisting-power of the patient's tissues, and (2) the amount of the poison present in his system. The attention of the author has been drawn to the fact that in fermentative processes (and most of these septic poisons are productive of fermentative changes) the resultants may be either of a gaseous or of a solid nature. In case of the latter, the patient's system must soon become charged with an overpowering amount of the poison, and symptoms of disease will manifest themselves; while in the latter case the poisonous products are eliminated by the lungs as fast as they are formed, and toxic affections are only manifested under very unfavorable surroundings or after long exposure to the influence of the poison. Given the case of a woman who has spent weeks before delivery in an atmosphere constantly charged with sewer emanations, and in whom vitality has been lowered by this cause in addition to the exhaustion, the impairment of nervous force, the stretching and bruising of tissues, and the presence in the blood of the products of

retrograde metamorphosis from the uterus and surrounding parts, consequent upon labor, and it is easy to understand how rapidly symptoms of blood-poisoning may develop and life be quickly endangered. It is no argument to say that if these things were so, cases would be more frequent in the poorer districts of our great towns.

Sewer-gas is sewer-gas, whether it is found in the hovel or in the mansion, and probably it exists quite as often in the mansion or villa with elaborate bad drainage as in the cottage and hovel with its open cess-pool or pit. But in one case we have the poor woman of coarser fibre and more resisting tissue, who spends a good deal of her time out of her house and away at work, and in the other the more refined but feebler patient, who spends much, perhaps, of her time in the bedroom or *boudoir*, which acts as a ventilating-shaft to the nearest soil-pipe.

In endeavoring to decide whether a given case of puerperal blood-poisoning is due to the influence of drain-products, the following points may aid in forming a diagnosis: 1. The rapid onset of symptoms after delivery. 2. The illness of the child as well as the mother; the improvement following a change of locality. 3. The type of the disease,—absence of intense prostration, the slow progress, only partial cessation of milk and lochia, rareness of peritonitis, and remissions of temperature. 4. Other cases of illness of a low type in the same house or neighborhood.—*Clinical Journal*, October 3, 1894.

The Arthritis of Varicella.—Drs. Braquehaye and de Rouville, in a review of this subject, state that varicella, like other eruptive fevers, may be complicated by arthritis during convalescence. The infection is secondary and due to the streptococcus. There are two forms,—one benign, resembling rheumatism, and terminating in resolution; the other, serious, suppurating and causing systemic infection. Both forms are accompanied by general symptoms and marked elevation of temperature. All the joints are attacked, either from the outset or successively. If little patients recovering from varicella were carefully examined, arthritis would be found present very frequently, as would varicella in children suffering from so-called idiopathic arthritis.—*Bulletin Médical*, September 30, 1894.

Interstitial Hernia.—Dr. Carless, of London, operated on a man, aged 20 years, who for some years had been suffering from interstitial hernia in the inguinal region. In stripping the structures of the cord from the neck of the sac it became evident that some abnormal condition was present; so the sac was opened, the index-finger inserted, and it was then found that a marked constriction existed opposite the external abdominal ring. Beyond this the sac again became dilated into a large pocket filled with omentum, more or less adherent to the wall and situated between the abdominal muscles. It had to be shelled out of its bed like a tumor; it was then opened above the constriction, the loose omentum was drawn down, and a considerable mass of it ligatured in portions and removed. The neck of this upper portion of the sac was dealt with by transfixion and ligature. The external oblique muscle was divided along the line of

the inguinal canal, so as to enable the surgeon more accurately to bring into apposition the upper curved fibres of the internal oblique and Poupart's ligament. The external oblique aponeurosis was also secured by a row of superficial stitches and the wound closed by continuous suture, no drainage being employed. Carless laid emphasis on the importance of opening the inguinal canal so as to enable the somewhat-depressed fibres of the internal oblique to be seen and accurately sutured.—*Medical Press and Circular*, September 26, 1894.

Some of the Contra-indications of Opium.—In a clinical lecture upon some of the uses of opium, Dr. W. B. Cheadle, of London, speaks a word of caution as to its use in Bright's disease, where profound and fatal coma may be produced, especially by its hypodermatic use. In cases of fatty or largely-dilated heart, the hypodermatic injection of morphia in full dose is attended with risk. Children are susceptible to its influence in inverse proportion to their age. He has seen fatal coma occur in a child of 6 months after a rectal injection of ½ drachm (2 grammes) of tincture of opium, and complete narcosis in a child of 14 months from 2½ grains (0.16 gramme) of Dover's powder. Another fact, usually ignored, should also be remembered, viz., that if opium has been given freely, its sudden stoppage causes great nervous depression, often severe vomiting and diarrhœa. This is the effect in cases of the opium-habit, and Dr. Cheadle has seen the same results follow the discontinuance of the drug in patients in which it had been given systematically. In exophthalmic goitre, for example, in which its use produces excellent effects, sudden discontinuance would be most disastrous. In these cases it is wise to let the patient down slowly and safely by gradual reduction.—*The Clinical Journal*, September 26, 1894.

Recent Suggestions in Therapeutics.

A Codliver-oil Tonic.—*Extract of malt*, 1½ ounces (46½ grammes); *pancreatized codliver-oil*, 1 ounce (31 grammes); *spirit of chloroform*, 1 drachm (4 grammes); *oil of cinnamon*, 6 minims (0.39 gramme); *water* to 6 ounces (186 grammes). A teaspoonful to be taken three times a day after meals. Of value as a food in building up the organism and increasing the heat of the blood in patients suffering from cold feet, physical and mental depression, headaches from exhaustion, aching of the nerve-centres; indolence of the digestive, menstrual, and other nerve-functions; intolerance of physical exercise, and subnormal temperature. (T. Robinson, *Lancet*, November 17, 1894.)

Antipyrin Mandelate.—A new preparation of *antipyrin*, formed by adding to the latter *mandelic acid*. Tried by the author in some 60 cases of whooping-cough, with failure in only 2 cases. Dose for infants under 1 year, 0.05 to 0.10 gramme (⅞ to 1¾ grains); for children between 3 and 5 years, 0.25 to 0.50 gramme (4 to 7¾ grains). (Rehn, *Münchener med. Woch.*, November 13, 1894.)

Chronic Lacunar Tonsillitis.—Throw a good light into the throat by means of the ordinary forehead reflector. Anæsthetize the tonsil with a 10- or 20-per-cent. *solution of cocaine.* This is not really necessary, as the operation is not painful. Depress the tongue with a spatula, inserting the point of the instrument into one of the cryptic orifices, and bringing it out at a neighboring orifice, or, if necessary, forcing it through the tissues. Cut through the intervening tonsil-tissue by simply rotating the handle of the instrument. Open up several crypts at one sitting, and evacuate any cheesy masses that may be present. If the tonsil is large, trim off any remaining loose tags of tissue with a pair of curved scissors. Divide adhesions between the tonsils and faucial pillars in the same manner as the crypt-walls. From two to three sittings or even more may be required for each tonsil, a week being allowed between each sitting. To diminish the tendency of the cut surfaces to unite, apply at the end of each sitting a solution containing *iodine* and *iodide of potassium*, each 90 grains (6 grammes); *water*, 1 ounce (31 grammes). Order a *boric-acid* gargle between the sittings. (JAMES B. BALL, West London Hospital, *Practitioner*, December, 1894.)

General Peritonitis.—Keep the patient without food for several days. Apply two or three leeches to the most sensitive portion of the abdomen, and supplement their action by thin poultices, Neapolitan ointment, or warm, soothing applications. Also give *calomel* in small doses after the leeches have been removed. Give internally a glass of iced water, containing 10 to 20 drops of *laudanum*, in teaspoonful doses, from time to time, to alleviate the pain. If this cannot be retained, give a small enema of tepid water containing 10 drops of *laudanum.* In six severe cases thus treated by the author the results were most satisfactory. (REVILLIOD, *Revue Médicale de la Suisse Romande*, October 20, 1894.)

Gonorrhœa.—If seen during the inflammatory stage, give *aloin pills*, 1 grain (0.065 gramme) each, to produce active purgation. This is an important point often overlooked. Not only does the *aloin* improve the appetite, but it also prevents chordee and gonorrhœal synovitis, and renders the inflammation less severe. Twist a fine layer of cotton-wool about a lucifer-match, cover it with ointment made of dilute *nitrate of mercury* to which *morphine* has been added 1 grain to the ounce (0.065 gramme to 31 grammes), and pass into the urethra three or four times a day. At the same time give an alkaline mixture containing *hyoscyamus.*

Should the case not be seen until three weeks have passed, give injections of *liquor plumbi subacetatis*, 1 drachm (4 grammes) to 6 ounces (186 grammes) of *chloroform-water*, with small doses of an emulsion of *copaiba balsam* by the mouth. Give *aloin* to prevent the dyspepsia and pain in the loins caused by the *copaiba.* (R. TURNER, Liverpool Seamen's Dispensary, *Practitioner*, December, 1894.)

One of the Best Injections for Neglected and Chronic Cases.—*Sulphate of zinc*, 3 grains (0.2 gramme); *tincture of catechu*, 10 minims (0.65 gramme); *tincture of opium*, 5 minims (0.32 gramme); *glycerin*, 15

Gonorrhœa—One of the Best Injections for Neglected and Chronic Cases (*continued*).

minims (1 gramme); *water* to 1 ounce (31 grammes). Always employ injection immediately after micturition. Introduce about ½ ounce (15 grammes) of the fluid into the urethra, allowing it to remain about one minute, then letting it flow away. (CARLESS, King's College Hospital, *Clinical Journal*, November 21, 1894.)

Gout.—Local application: *bicarbonate of sodium*, 1 part; *linseed-oil*, 9 parts. Wrap affected joint in a piece of liniment soaked in this mixture. (HARE, Jefferson College, *College and Clinical Record*, November, 1894.)

Guaiacol Externally in Tuberculosis.—Method of using the drug at the Home for Consumptives, Chestnut Hill, Philadelphia: Wash and dry the skin well over the place selected for the application of the remedy, preferably over the seat of the greatest lesion of the lung. Pour 10 minims (0.65 gramme) or more of *guaiacol* into a dish, and apply with a camel's hair pencil, brushing backward and forward until the whole dose has been absorbed. This will require ten or fifteen minutes. Rub the part dry with the hand, and cover with a layer of cotton protected by paraffin paper or oiled silk. When carefully employed in this manner, the drug controls high temperature and promotes the comfort of the patient much more satisfactorily than by ingestion, subcutaneous injection, or direct injection through the air-passages. (J. SOLIS-COHEN, *Medical News*, November 24, 1894.)

Hiccough.—D. L. Parker, of Detroit, has cured several cases of severe hiccough by dry cupping of the abdomen. The theory is that by drawing forward a portion of the abdominal wall, and thereby tending to enlarge the abdominal cavity, enough force is exerted upon the upper side of the diaphragm by atmospheric pressure to overcome its spasmodic action. It is curious to note that the spasm returned in all four cases reported in about two hours,—a fact which the author is unable to explain. In all four a repetition of the cupping caused a permanent arrest of the hiccough. An ordinary drinking-glass may be used, the air being exhausted by burning paper or a few drops of burning *alcohol*. In removing the glass, care should be taken to press lightly upon the skin near the edge of the glass with a pencil or other pointed instrument, and allow the air to pass in gradually. Forcible removal is quite painful. (*Physician and Surgeon*, October, 1894.)

Infants' Food.—Add an equal quantity of water to good cows' milk, and place in a centrifugal separator, to remove all impurities, such as hairs, etc. The fluid which runs from the cream-tap of the separator is very much like human milk, except that there is less sugar. (GARTNER, *Allgemeine Wien med. Zeitung*, October 13, 1894.)

Lemon-Juice as an Hæmostatic.—In epistaxis, inject into the nostrils a mixture of lemon-juice, 1 in 4, using a common glass syringe. In hæmatemesis and hæmorrhage of typhoid fever, given internally, it was also

Lemon-Juice as an Hæmostatic (*continued*).
successful in the author's hands. (E. T. BURTON, *British Medical Journal*, November 2, 1894.)

Nutrient Blood-Coagulum as a Culture-Medium.—Collect the blood of an animal in a sterilized jar or bottle. As soon afterward as possible, fill small sterilized glass test-tubes one-quarter full of the pure blood before it has clotted, or of the colored fluid portion which has separated if clotting has already begun. Place the tubes in a slanting position in a small tin box in a water-bath, and heat slowly until the water in the bath begins to boil. Continue boiling for ten minutes or longer, until the blood has coagulated and become solid. It then has a chocolate color and a moist appearance, and from a stroke-culture of the diphtheria bacillus on its surface a diagnosis can be made in ten hours. If necessary to keep the tubes for any length of time, they can be sterilized at a temperature of 85° C. (185° F.) two or three times without injuring the medium. The preferable temperature for the diphtheria bacillus is from 36° to 37° C. (96.8° to 98.6° F.). To insure this constant temperature, place the inoculated tube in a wooden case or other receptacle to prevent breaking, and keep it in close contact with the human body. (M. V. BALL, *Medical News*, November 24, 1894.)

Pyelitis and Cystitis.— ℞ *Potassii citratis*, 4 drachms (16 grammes); *spirit. chloroformi*, 3 fluidrachms (12 grammes); *tinct. digitalis*, 1 fluidrachm (4 grammes); *infusi buchu*, 8 fluidounces (250 grammes). M. Sig.: A dessertspoonful t. d. (HARE, Jefferson College, *College and Clinical Record*, November, 1894.)

Synovial Cysts.—Wash and disinfect the skin. Inject with a Pravaz syringe, previously sterilized, several drops of pure *tincture of iodine* into the most prominent portion of the cyst, taking the precaution to draw the skin lightly to one side, so that the puncture in it will not correspond to that in the wall of the cyst when the needle is withdrawn. Insert the needle deeply enough to penetrate the centre of the cyst, and evacuate by a single movement the number of drops intended, so that it will penetrate into the interior of the cyst and become mixed with its contents. It is sometimes necessary to exercise considerable pressure, particularly when the cyst is hard or thick. Leave the needle in place for a few seconds after the injection, and then draw it out with a single rapid movement. Compress the surface with the index finger to prevent the escape of the *iodine*. From 5 to 12 drops of the remedy are sufficient, according to the size of the tumor. Apply over the site of puncture a tampon of aseptic cotton, cover the joint with several layers of cotton, and secure it with a bandage sufficiently tight to compress the tumor and immobilize the joint. Remove the bandage on the third or fourth day, when the cyst will be seen to have greatly diminished in size. If necessary, continue the depression and immobilization for a few days longer. If the cyst has not diminished in size,

Synovial Cysts (*continued*).

owing to its calibre or volume, make a second injection of *iodine*, using a few drops more than at first. This will insure a definite cure within from six to twelve days. (PROFESSOR DUPLAY, Hôtel-Dieu, *Archives Générales de Médecine*, December, 1894.)

Typhoid Fever.—To combat delirium at onset of disease: Lukewarm baths, gradually lowering the temperature; if the patient complain of their length, give baths of fifteen minutes, with cold affusions on the head. If the delirium return, keep compresses of vinegar and cold water or of ice on the head, renewing them frequently. If the delirium occur in the second week, is excessive, and accompanied by insomnia or a desire to get out of bed, give calmatives, as following: *Chloral*, 2 or 3 grammes (31 to 46 grains); *bromide of potassium*, 3 or 4 grammes ($\frac{3}{4}$ to 1 drachm); *syrup of morphine or opium*, 30 grammes (1 fluidounce); *cherry-laurel water*, 5 or 10 grammes ($1\frac{1}{4}$ to $2\frac{1}{2}$ drachms); *linden-water*, 130 grammes ($4\frac{1}{3}$ fluidounces). If the heart is weak, *chloral* is contraindicated; if there is albuminuria, scant urine, or tendency to constipation, *opium* should not be given; if the stomach is intolerant, the *bromides* cannot be administered.

For the delirium occurring in the third week, order nourishing drinks, peptones in bouillon, milk, or good wine. Give the following: *Extract of opium*, 0.05 to 0.10 gramme ($\frac{7}{8}$ to $1\frac{3}{4}$ grains); *tincture of cinnamon*, 2 grammes (31 minims); *port* or *Bordeaux wine*, 60 grammes ($1\frac{3}{4}$ fluidounces); *water*, 60 grammes ($1\frac{3}{4}$ fluidounces). (LE GENDRE, *Thérapeutique de la Fièvre typhoïde*, Paris, 1894.)

Monographs Received.

The editor acknowledges, with thanks, the receipt of the following monographs:—

Des Effets du Traitement Mercuriel intense et précoce sur l'Evolution de la Syphilis, par **Louis Jullien**, Paris, 1894.——Piperazina and other Eliminants in the Treatment and Prevention of Gout, by **E. D. Mapother**, London, 1894.——Ueber Hautschienen, Ein Beitrag zur mechanischen Behandlung der Hautkrankheiten, von **M. F. Engman** and **P. G. Unna**, Hamburg.——Old and Neglected Deformities following Infantile Spinal Paralysis, by **S. L. McCurdy**, Pittsburgh, Pa.——Some Meteorological Data, by **Samuel A. Fisk**, Denver, Col.——Arsenite of Copper as an Antispasmodic, by **W. B. Stewart**, Philadelphia.——Trephining in Three Cases of Epilepsy, by **J. T. Eskridge**, Denver, Col.——A Case of Chronic Peritonitis, by **Frederick Holme Wiggin**, New York, 1894.——Tubercular Abscesses and their Treatment, by **S. L. McCurdy**, Pittsburgh, Pa.——Laminectomy for Tubercular Spondylitis, by **Carl Beck**, New York.——Ueber die Behandlung des Typhus Abdominalis mit Abgetödteten Pyocyaneus-Culturen, von **Fr. Kraus** and **H. C. Buswell**, Vienna, 1894.——Pyothorax and its Treatment, by **Carl Beck**, New York, 1894.——Nouveaux Essais de Topographie Cranio-Encéphalique, par **E. Masse** and **J. Wooloughan**, Bordeaux, 1894.——Beitrag zur Hauttuberculose, von **Doutrelepont**.——Transactions of the American Ophthalmological Society. Thirtieth Annual Meeting, Washington, D. C., 1894.——Appendicectomy: Three Instructive Cases, by **G. G. Cottam**, Rock Rapids, Iowa.——Hæmatoma of Ovary, by **George H. Rohe**, Catonsville, Md., 1894.——A New Apparatus for Administering Anæsthetics, in Face and Mouth Operations, by **Edmond Souchon**, New Orleans, La.——L'Asthme des Foins et le Coryza Spasmodique, par **J. Molinie**, Marseille, 1894.——Intestinal Obstruction following Operations in which the Peritoneal Cavity is Opened, by **George H. Rohe**, Catonsville, Md., 1894.——On Tubercular and Suppurative Peritonitis, by **Carl Beck**, New York.——The Use of Traction in the Treatment of Joint Diseases, by **S. L. McCurdy**, Pittsburgh, Pa.——New Instruments, by **S. S. Bishop**, Chicago, Ill.——Spindle-Cell Sarcoma and Epithelioma, by **W. B. Stewart**, Philadelphia, Pa.——A Retaining Splint for Excisions of the Hip-Joint, by **S. L. McCurdy**, Pittsburgh, Pa.——A Few Points on the Treatment of Carcinoma Mammæ, by **Carl Beck**, New York.——Three Unusual Cases of Abscess, by **M. A. Veeder**, Lyons, N. Y.——Contribution à l'Étude de l'Ulcère Perforant de la Cloison du Nez, par **E. J. Moure**, Bordeaux, 1894.

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(End of Editorial Department of Journal for January, 1895.)

"PEPTO-MANGAN" FOR ANÆMIA IN PULMONARY TUBERCULOSIS.

Dr. Karl von Ruck, Director of the Sanitarium for Diseases of the Lungs and Throat, Asheville, North Carolina, contributes, in *The New York Medical Journal* of December 15, 1894, an article on the value of "Pepto-mangan" in building up the blood of patients suffering from anæmia due to pulmonary tuberculosis. In the tabulated statement of cases treated by this new remedy there is much food for the thoughtful physician. The results were very gratifying and leads one to suppose that this new agent (Pepto-mangan) possesses not only the power of arresting further blood deterioration, but actually supplies to the blood the elemental constituents necessary for rebuilding wasted tissue. The six weeks' test of "Pepto-mangan" by Dr. von Ruck, to say the least, is encouraging, and we trust other physicians having the facilities for observation will, in the cause of medical science, extend these tests still further. Every physician would be pleased to see his anæmic patients gaining in weight, and also to know that the blood was being revivified by those constituents necessary to a return to health.

One feature of the doctor's test must not be overlooked, that the stomach, although in such cases very irritable, retained "Pepto-mangan"; no disturbance of digestive function occurring nor constipation supervening.

In the article referred to the doctor states that "in all cases the improvement in blood condition was highly satisfactory; in quite a number phenomenal."

We commend the doctor's communication in its entirety to the thoughtful physician.

TARPON SPRINGS—THE AMERICAN RIVIERA.

The Tarpon Springs region seems to be rapidly gaining in favor among the medical profession. Every day brings evidences of this fact. All testimony seems to point to its being an absolutely ideal region for those suffering from pulmonary and catarrhal difficulties, as well as from rheumatism and nervous affections.

The hotel, under the management of H. G. Marvin & Co., makes a most desirable stopping-place. Parlor-cars are now run on the Florida Central and Peninsular Railroad to Lacoochie; so that persons wishing to reach Tarpon Springs can leave Philadelphia in the morning of one day, reaching Tarpon Springs upon the evening of the succeeding day.

Encircled by the Anclote River, the Salt Lakes, Lake Butler, and several beautiful bayous and the Gulf, there is perhaps no spot in America where the opportunities for pleasure, and especially for those who are fond of the water, are so great. A steam-launch is connected with the hotel, taking parties to the Gulf, up the river, and on other excursions. It is said that the black-bass fishing in Lake Butler cannot be surpassed upon the continent.

The regattas held at Tarpon Springs have been celebrated for several years, having grown from a local fame to be known and looked for far and wide. The present winter will probably witness finer gatherings and more interesting races than any previous year.

We have recently been shown letters from a number of prominent physicians relating to the healthfulness and climatic advantages of this particular region, and all unite in speaking of it in the highest possible terms. It would seem, from evidences produced, that physicians cannot go wrong in sending their patients to this delightful place.

THE

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IN ALL PARTS OF THE WORLD.

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Selections from Society Proceedings.

AUSTRIA.

K. K. GESELLSCHAFT DER AERZTE IN WIEN.

Serum Therapy of Diphtheria in Vienna.—In the discussion of this subject DR. GNANDINGER gave the statistics of the Crown Prince Rudolph Hospital, showing that the antitoxin treatment was attended with no unpleasant results and that the number of recoveries was equal to, if not greater than, under any method previously employed. Of 27 cases, there were 11 deaths,—a mortality of 40 per cent., against 45.5 per cent. in previous months. The streptococcus and staphylococcus were found associated with the Löffler bacillus in almost all the cases.

DR. HEIM, physician to St. Joseph's Hospital, treated 27 cases with the serum, from the beginning of October to the 4th of November, with 6 deaths,—a mortality of 22.2 per cent. From the 4th of November to the 18th of December no serum could be obtained, and during this time there were 32 cases treated by ordinary methods, with 21 deaths, or 65.6 per cent. From the 18th of December to the 10th of January last 21 cases were treated with the serum, with a mortality of 28.5 per cent. The mortality of the disease at this institution in 1894, before the serum was used, was 52.5 per cent., and the average mortality for the past ten years 51.1 per cent. Albuminuria was noted eight times during the serum treatment, but it was found to have existed previous to the injections. Nephritis was not more frequently observed than in the past. Dr. Heim had observed two cases of paresis of the vault of the palate and five cases of scarlatiniform erythema, not, however, followed by desquamation. The effect of the injections on the pulse, temperature, and general condition was quite favorable; the local action upon the false membranes could not always be observed, and particu-

larly the milky aspect described by some authors. In cases of laryngeal diphtheria there was often a rapid diminution of the symptoms of stenosis.

PROFESSOR MONTI reported 25 cases treated with the serum,—23 by Behring's and 2 by Roux's. Only one death occurred among these patients, the case being that of a boy, 7 years old, weakened by a previous attack of pneumonia and bronchiectasis. Tracheotomy was performed, but death took place six days later. Professor Monti stated that the apparent discrepancies in the various statistics furnished was due not only to the brief time of observation, but also to the fact that authors were not yet thoroughly in accord upon the subject of diphtheria, either clinically or bacteriologically. A classification based upon pathological anatomy permits of the division of the disease into three classes: (1) fibrinous diphtheria, in which only the Löffler bacillus is present; (2) phlegmonous or mixed, in which the Löffler bacillus is associated with the streptococcus; (3) gangrenous, in which various bacteria are associated with the Löffler bacillus. The first form is the least fatal, and 10 of Professor Monti's cases belonged to this class. In 13 the streptococcus was also found and in 1 case only the streptococcus. In 9 cases the Löffler bacillus disappeared with the local symptoms, and in 14 it was present afterward, in 1 case being found on the fourteenth day. In 12 cases paralysis appeared, which was attributed to the large doses of antitoxin employed. In 13 cases there was transitory albuminuria, without general symptoms, and in 1 case casts were found in the urine. An erythema occurred in 6 cases, urticaria in 7 cases, and lymphangitis in 1 case. Professor Monti believes that the serum produces wonderful results in the fibrinous form of diphtheria, but that in the more complicated forms the effects are not so marked.

DR. UNTERHOLZNER stated that at the Leopold Hospital for Children 31 cases were treated with antitoxin, with a mortality of 25.8 per cent., and 36 were treated by other measures during the period in which serum could not be obtained, with a mortality of 66.7 per cent. The good effects of the antitoxin were thus brought forward strikingly by the great mortality during the time the supply of the remedy was exhausted.

FRANCE.

SOCIÉTÉ DE MÉDECINE ET DE CHIRURGIE PRATIQUES.

Diphtheria in a Child of Seven and One-half Months Cured by Antitoxin.—DR. PAUL DUCOR described the case of a boy of 7½ months, healthy, breast-fed, and who had never been ill, who, two days previously, had been suddenly affected with a strident cough, the breathing at times being sibilant and noisy. Except during the attacks of cough the child was calm and took the breast readily, swallowing apparently without difficulty. Auscultation revealed nothing and was interfered with by the want of docility of the child and the production of an inspiratory sound which obscured the vesicular murmur. Fever was moderate, the rectal temperature being 38.1° C. (100.6° F.).

Without making an immediate diagnosis, Dr. Ducor ordered the lower limbs to be wrapped in cotton, and local applications of salicylated glycerin to be made to the affected parts, with frequent irrigation with warm boric-acid solution. He refrained from the use of carbolic acid or sublimate, intending later, if necessary, to use Roux's serum, which experience had shown is less efficacious in children previously treated by these two drugs. There was no change on the following day, but the next night the child was excited, the temperature reached 38.4° C. (101.2° F.), and the oppression appeared to be more marked. Although there was no trace of false membrane, Dr. Ducor decided to make a bacteriological examination. He therefore removed some of the mucus from the posterior pillar of the fauces by means of a spatulum sterilized in flame and cooled before being introduced into the throat of the patient; with this he made cultures in two tubes containing sterilized beef-serum, and the Löffler bacillus developed in due time, as well as many streptococci. Without waiting for the development of the culture, however, he injected 20 cubic centimetres (5 fluidrachms) of antitoxin under the skin of the thigh. At the time of the injection the rectal temperature was 39.2° C. (102.6° F.). There was no general reaction. The following day the patient was more comfortable, but the next night the oppression became again more marked and the breathing was much disturbed by collections of mucus in the nose. These accumulations were removed as often as possible and the irrigations continued during the following day. In the evening a second injection of 20 cubic centimetres (5 fluidrachms) was given. The cough now completely lost its croupous character and the diphtheritic element entirely disappeared, as shown by another bacteriological examination. Bronchial pneumonia, however, developed and ran its course with all the classical signs of that disease. This condition was undoubtedly due to the presence of the streptococcus. The child recovered perfectly, and Dr. Ducor states that recovery at so early an age was so rare that Dr. Jules Simon, to whom he communicated his case, declared that he was not aware of a similar instance. MM. Roux, Martin, and Chaillou have reported one case of a child, 4 months old, treated by antitoxin and tracheotomy in which recovery took place.

Dr. Ducor insists upon the evident good effects of slightly-acid irrigations in connection with the serum, believing that in this way the diphtheria was prevented from spreading to the pharynx.

Société de Biologie.

Thyroid Extract in Obesity.—M. Charrin treated a patient in the service of Professor Bouchard with thyroid juice, giving 1 gramme (15½ minims) daily, either by subcutaneous injection or by the mouth. In three months her weight fell from 133 to 115 kilogrammes (292½ to 253 pounds). As soon as the treatment was discontinued the loss of flesh also ceased, and when the thyroid extract was resumed a daily loss of 50 to 130 grammes (1⅔ to 4⅓ ounces) was observed, this becoming less after a time. A second case treated showed similar but less marked results, while in a third no

effect could be noted. M. Charrin stated that similar cases in which the remedy had had no effect had been observed by others, and that the inconstancy of results perhaps depended upon the different forms of obesity, upon the insufficiency of the treatment, or upon the extract used, which may not have been genuine. His patients, who were not myxœdematous, showed no signs of that disease during the treatment, which was carefully carried out.

GERMANY.

Berliner medicinische Gesellschaft.

Cases of Trephining.—Herr Naser showed two successful cases of trephining after traumatic brain affection. He makes a distinction between late and early cerebral abscess. The late abscess apparently does not arise in the contused part itself, but in a healthy one, just like non-traumatic abscesses after traumatic suppuration in the bones and soft parts. These late abscesses generally lie deep, and are covered by normal cerebral cortex. The early abscesses usually arise in the injured area, into which infective material penetrates from without. Fatal meningitis is often associated with immediate suppuration. If the suppurative process is slower, however, and the wound in the brain small, adhesions of the cerebral membranes take place in the region of the injury, and abscesses may result. These abscesses are, to a certain extent, the result of retention of pus in the nests and sacs of a deep wound, are generally superficial and cortical. They do not develop before two weeks. Very early onset of paralysis or symptoms of irritation are rather signs of meningitis, whilst the late appearance of symptoms point rather to abscess. In the first case described by the speaker the injury was caused on September 10th by a heavy chisel penetrating the skull with the sharp point. The patient was rendered unconscious, and cerebro-spinal fluid was discharged. The wound suppurated. Eleven days after the injury there was contraction of the mouth and diminished power of speech. These symptoms became aggravated, and violent headache and apathy came on. On September 22d the patient was admitted into the hospital in a state of apathy, but quite conscious and completely aphasic. There was paralysis of the lower branches of the facial, but no disturbance of sensation or motility, and no general symptoms of cerebral pressure. Respiration and temperature were normal. From two to three finger-breadths to the left of the median line, near the coronary suture, was a suppurating opening two centimetres in length. Cerebral abscess was diagnosed on account of the length of time that had elapsed since the injury. On the 26th there was greater apathy, with motor weakness of the right arm, less in the right leg. Trephining was done at once, and after deep exploration pus welled out. The finger now introduced distinguished an abscess-cavity the size of a walnut. Immediate relief of all the symptoms followed the operation, and steady improvement has continued.

The second case was that of a little boy who was brought to the clinic on October 25th. A heavy piece of wood had fallen on his head six days previously, and a screw on the wood had penetrated deeply into the left side of the head. The boy had run away crying. Suppuration took place on the fifth day, the speech was affected, and facial spasms occurred extending to the arm. After a violent attack transitory paresis of the arm and complete aphasia occurred. Almost in the same place as in the first case was a small, suppurating, perforated wound. Symptoms of irritation predominated, but the general condition and sensorium were not affected. The late onset of the cerebral symptoms was against the assumption of pure traumatic irritation, and the good general condition was opposed to meningitis or abscess. On chiseling away the bone around the wound Herr Naser found the internal table extensively split, the dura mater free and much torn, and a reddish-brown brain-substance protruding through the rent. On passing in the forceps a quantity of splinters were found. The finger showed the brain-substance to be normal, without suppuration. The case was one of simple bruising of the brain with irritation, produced by splinters of bone. Uninterrupted recovery followed.

Pseudoparalysis Myasthenica.—Herr Jolly described the second case of this kind that he had seen, the first having ended fatally. In the present one the condition permitted a more favorable prognosis. The boy, aged 14½ years, was healthy until the commencement of the present illness. There was no nerve disease in the family. When 1½ years old he had had fits lasting some days, but no recurrence. He had been quite strong, with good muscular development, and was an expert climber. The illness began in the summer of 1893. The first symptom observed was that the boy could not see the blackboard properly, as it was impossible to keep his eyes open for any length of time, the eyelids failing after continued exertion. After rest and in the morning the weakness was not present, but came on again after continued looking. The next symptom was a tired feeling in the legs, at first on mounting steps, but afterward on simple walking. In a short time he became so fatigued with walking that he would suddenly fall in the street, but without loss of consciousness. After resting a short time he was always able to walk on a number of steps farther. Some months later the same symptoms appeared in the arms, and later on in the muscles of mastication and lips, so that at last the patient could not articulate. In the case first observed there was similar fatigue of the pharyngeal muscles. All the muscles were thus affected, losing their power after short activity, to become active again after rest. The ptosis, which at first had been so marked, was now present in much less degree, so that the boy could keep the eyes open for a quarter of an hour at a time. The fatigue in chewing was less, and in swallowing there was none at all, whilst in his first case the patient could not swallow after a few times, and died suddenly whilst eating. Electrical irritability appeared at first to be normal, but, if the current were kept up somewhat longer, fatigue soon showed itself. The abnormality must be in the muscles themselves, and consisted in an alteration of the chemical condition on which the contraction depended. Some alkaloids

induced a similar condition, such as veratrine, physostigmine. As regarded the myasthenic condition, Professor Böhm, of Leipzig, had stated that it depended on a similar alkaloidal action, that of protoveratrine. There must, therefore, be an abnormal condition in the muscles in these cases. There was the question, also, of the central nerve-change, something similar to that described by Benedikt in 1868 as the "reaction of exhaustion."

As regarded treatment, the muscles should be spared as much as possible, and when the patient could no longer swallow he should be fed by enemata. Electricity was useful, and arsenic also, and some alkaloids might have an action antagonistic to the condition.—*Medical Press and Circular*, January 19, 1895.

GREAT BRITAIN.

BRITISH MEDICO-PSYCHOLOGICAL ASSOCIATION. SCOTTISH BRANCH.

Hæmatoporphyrinuria following the Administration of Sulphonal.—DR. L. R. OSWALD related at length the history of a woman admitted to the Glasgow Royal Asylum, in August, 1893, for acute mania, from which she had been suffering for a couple of weeks.

There had been no previous bodily or mental illness, though there was an hereditary predisposition to insanity and marked allied neurosis in the family history. She was at first given paraldehyde when it was necessary to produce sleep, and after a couple of months appeared to be on the way to recovery. The urine contained traces of albumin. When an hypnotic was required she was given chloral and bromide. In November she had a relapse, and in January, 1894, a burst of great excitement. Chloral and bromide seemed not to act very well, and in the middle of April, as she was in a state of chronic excitement, she was given sulphonal for the first time in doses of 15 grains (1 gramme) twice daily. This was continued regularly till about the middle of July, but in varying doses, from 15 to 30 grains (1 to 2 grammes), according to the condition. For a couple of weeks she was quieter and the drug was given rarely; but in the beginning of August it was resumed in 10-grain (0.65 gramme) doses twice daily and continued until August 23d, when an illness set in which proved fatal in eleven days. In all she took 2200 grains (70½ ounces) of sulphonal. The doses were not large and the drug had seemed to act well, procuring sleep, lessening excitement, and calming the patient without producing any evident injurious effect. The following morning, August 24th, vomiting occurred, with abdominal pain and tenderness about the umbilicus on pressure. No urine was passed that day; but the next morning that passed was found to be scanty, of dark color, and, microscopically examined, to contain many altered blood-discs. The color was evidently due to hæmatoporphyrin. The patient continued in much the same condition from the 26th to the 31st, when she seemed better and retained a little peptonized milk. The pulse was fuller and the claret color was absent from the urine. After a restless night she complained next morning of numbness of the hands and feet,

and before evening was unable to move them. Her mental condition was clearer, and she localized impressions and their character correctly. The paralysis increased, however, and urine and fæces were passed involuntarily. The next day she grew gradually weaker and died at midnight, the temperature being at 100° F. (37.8° C.). During her illness there was a great decrease of blood-corpuscles, but some days before death they increased, showing that the destructive process had apparently stopped. Dr. Buchanan made a microscopical examination of the liver and kidneys, finding the former in a state of generalized fatty degeneration, the fat being mostly in a finely-divided form. The kidneys presented a notable departure from the normal, the renal epithelium being homogeneously granular and the outlines of cells and nuclei almost entirely lost. In sections hardened in Müller's fluid and stained with alum-carmine the granular appearance of the nuclei was retained; but the cells of the convoluted tubules, with the exception of a coil here and there, did not show nuclear staining, and the same was true of many of the straight tubules. The connective-tissue nuclei had also in great part disappeared, as well as those of the vessel-walls.

As albumin had been noted in the urine prior to the fatal illness, the changes in the kidney were probably due, at least in part, to previous renal disease. This would undoubtedly be aggravated by the irritative action of the excretion of hæmatoporphyrin and allied substances, as it has been determined that injections of blood-serum containing hæmatoporphyrin produce considerable irritation of the kidneys and changes in the urine.

Dr. Oswald stated that about forty cases of a similar nature had been reported, all in women, and over one-half of them terminating fatally. From these cases it must be admitted that the hæmatoporphyrin in the urine in such quantities is directly due to the sulphonal. When the cases for its administration are carefully chosen its value as an hypnotic cannot be called in question; but when the bodily condition is poor and the patient anæmic it is difficult to see the value of a drug that has been shown to lead to the appearance in the urine, in variable quantity, of the decomposition products of hæmoglobin. In cases of *folie circulaire*, though it lessens the excitement, it seems to render the stage of well-being less bright and clear intellectually. As a temporary hypnotic for acute cases in private practice, and as a sedative for chronic and incurable cases of excitement, it is of great service; but it must be given with care and watchfulness, as symptoms of great severity may arise with little warning, and the life of the patient be endangered.—*Glasgow Medical Journal*, January, 1895.

The Indian Medical Congress, Calcutta.

Constitutional Malaria in the Tropics.—Surgeon-Major L. T. Young considered the pathological condition produced by malaria and the functional effects of alkaline salines. Even a rather casual inspection at numerous necropsies leads to the adoption of the opinion that malaria congests the internal organs and causes catarrh of the mucous membranes. A proper recognition of these two facts and their results

may be considered the key to the successful treatment of the constitutional effects of malaria. It is rare at an Indian necropsy to find a liver free from congestion of some form or other. In many instances the appearances are distinctly those of incipient "nutmeg" congestion; whilst in advanced malarial cases there is distinct cirrhosis of an hypertrophic kind, following, to some extent, as the result of long-standing congestion, according to the well-known pathological law. This cirrhosis is not the ordinary "hob-nailed," contracted surface form, but the enlarged, hypertrophic, morocco-leather surface form, which commences in and around the bile-ducts, and which, he suggested, begins as a catarrh of these channels in a manner similar to that in which catarrhal malarial enteritis supervenes on tropical intestinal catarrh. Tropical hepatic congestion is always associated with more or less fatty infiltration of the liver-cells. The acute results comprise hepatitis, abscess, perihepatitis, dysentery, catarrh of the bile-ducts, etc. The chronic results embrace the various forms of imperfect proteid metabolism or liver indigestion; also gout, rheumatism, and possible diabetes, etc. The early congested and the late cirrhotic stages of the spleen are only too well known. The organ or its capsule sometimes becomes inflamed; the enlargement of the organ may reach an enormous size, sufficient to almost fill the entire abdomen. In the later stages ascites supervenes, anæmia and debility, with a tendency to sudden death from pulmonary thrombosis, as so ably described by Sir Joseph Fayrer. These kidneys are nearly always found congested, often intensely so. Of the later stages the large white kidney has been the most frequent in his own observations, not the cirrhotic form as one would have expected. Acute desquamative nephritis is not a rare complication of severe malarial fevers, and it is often in the slighter degrees overlooked, and gradually assumes the fatal chronic form. The dietetic errors to which Anglo-Indians as a class are so much addicted are also largely to blame for many cases of Bright's disease. All the mucous membranes of the body become sooner or later affected by catarrh from malaria and residence in a tropical climate. Pharyngeal and laryngeal catarrhs are generally the earliest to occur. The latter spreads with great frequency up the Eustachian tube, giving rise to otitis media, which often goes on to suppuration with loss of the membrana tympani and ossicles, or to plastic inflammation sealing up the ossicles into the fenestræ, and so causing deafness. The Schneiderian membrane shares the same fate, and hyperplasia of it over the turbinated bones is a common result. Slight chronic ophthalmia attacks the conjunctivæ. The lining of the uterus becomes endometritic. The most important catarrh, however, is that of the stomach and intestines. Under the influence of repeated "long drinks," large meals, and hot weather the stomach becomes dilated, its glandular structures degenerate and atrophy, leading to the secretion of gastric juice imperfect in quality. An ague patient who has had a drink of milk half an hour previously brings it up perfectly uncurdled, showing the complete absence of acid from his stomach. The thickly-loaded, large, flabby, indented "tropical tongue" is a frequent sign of tropical gastric catarrh. The intestinal catarrh often causes not alone obstructive jaundice,

but ramifies and extends along the bile-passages in its more chronic forms. This, as already suggested, may act as the starting-point of biliary cirrhosis. Catarrhal enteritis is a common and extremely fatal consequence of extension of intestinal catarrh to the substance of the intestine from its mucous membrane, and its occurrence is favored by the mechanical obstruction to the return of blood from the chylopoietic viscera by a chronically-congested liver. This enteritis is not a sthenic form of inflammation accompanied by the exudation of lymph, nor does it usually excite the overlying peritoneum to effusive inflammation. The bowel—usually pale, thinned, and anæmic from a malarial atrophy—is, when enteric, darkly congested, thickened, and its mucous membrane soft and vividly injected. The peritoneal side of the bowel is also red and injected. Long tracts of the bowel are not affected in this intense manner, but only patches of a foot or two. The spaces between these present all the signs of chronic congestion or of incipient inflammation, with signs of vascular dilatation and blood-stasis. The congestion is usually most marked about the ileum. There is no trace of any ulceration of Peyer's patches or of the mucous membrane. A patient who recently died at the Umbala Hospital from this affection had grass-green diarrhœa, just like a child with irritative diarrhœa. The color of the motions in diarrhœa is mostly either pale or dark. I have not often seen it green in adults. Malarial degeneration or atrophy of the heart also occurs in advanced cases. This organ is found pale, thin, small, and flabby. The ventricular walls are reduced to about half their normal thickness. There are atrophy and fatty degeneration of the muscular tissue. Severe and long-continued malarial fevers often produce paresis or paralysis, motor or sensory, or both, of the lower limbs. This was found to be due to spinal pachymeningitis.

In regard to the treatment by Carlsbad water, the speaker said that patients must be prepared to devote two hours each morning to drinking the water in the proper manner. On getting up in the morning a dose of 6½ ounces (200 cubic centimetres) of the natural or artificial water made from the salts and warmed to a temperature of 120° F. (48.9° C.) should be slowly sipped as it cools. After this a walk of twenty minutes in the open air is taken, and then another 6½-ounce dose; a second walk of twenty minutes and a third similar dose are next indulged in. This is followed by a walk of one hour, after which the patient can have a simple breakfast. Some patients are given an extra dose of the water at 11 A.M., and another on going to bed at night. This latter has a great effect in cleaning the thickly-furred "tropical tongue." During the course the following articles of diet are strictly excluded: fresh fruit, salads, acids, cheese; tinned, dried, or smoked fish, and butter. Sweets, greasy dishes, and strong wines or short drinks are also to be avoided.—*Lancet*, January 19, 1895.

Clinical Society of London.

Loculated Empyema.—Dr. J. W. Browne described the case of a strong man, aged 46, with a vague history of syphilis and spinal neuralgia, who,

between September 25, 1891, and April 1, 1892, had symptoms which suggested to different observers the diagnosis and treatment that follow: September 25th. Gall-stones. September 30th. Perihepatitis or hepatic abscess, with right pleurisy or empyema. October 8th. Some abdominal lesion, necessitating exploratory incision, which was made with negative results. October 17th. Right pleurisy, displacing heart; also left pleurisy, probably due to abscess of liver or vertebral disease. October 18th. Paracentesis of right thorax, with negative results. October 28th. Escape of pus from left pleura into left lung; pericarditis. October 31st. Limited left pneumothorax; consolidation of left lung. November 21st. Double pleurisy, probably by extension; no present or past pneumothorax; displacement of stomach; gall-stones which had no causal association with the pleurisy. December 1st. Collapse of left apex; consolidation of left base, syphilitic or tuberculous. December 7th. Successful operation for loculated left empyema. After this the patient grew rapidly better, but some symptoms persisted, which invited still further explanations of his previous and present state. March 17, 1892. Hydatids at back of liver. April 1st. Encapsulated pus at right base; shortly afterward he recovered his full health and strength, with the exception of pain and weakness in his lower limbs after exertion.—*British Medical Journal*, January 19, 1895.

UNITED STATES.

College of Physicians of Philadelphia.

Strontium Salicylate.—Prof. H. C. Wood calls attention to this drug as one likely to prove a valuable addition to every-day therapeutics. After using the lactate, iodide, and bromide of strontium very freely, he came to the conclusion that the strontium element materially modified the action of haloid bodies on the alimentary canal. This suggested the possibility that strontium might modify the action of salicylic acid; so he had a strontium salicylate prepared, and experimented with it upon dogs, determining that in therapeutic doses it elevates the arterial pressure, and that to depress the blood-pressure and circulation larger amounts of it per kilo (2¼ pounds) are required than of the sodium or even of the ammonium salicylate. He afterward employed it largely in practice, and found, somewhat to his surprise, that in doses of 5 grains (0.32 gramme) it is one of the best of intestinal antiseptics, yielding better results than salol, naphthalin, and similar agents. In doses of 10 or 15 grains (0.65 to 1.0 gramme) it acts very decidedly as a salicylate in gouty and chronic rheumatic conditions without producing disturbance of the stomach. It may be given in capsules. When large quantities are administered it produces cinchonism, but it seems to be less active and powerful in acute cases than is the ammonium salicylate. In chronic gouty conditions and lithæmia with intestinal indigestion it appears to be the most valuable drug that we have.—*British Medical Journal*, January 5, 1895.

Appendicitis.—Dr. John B. Deaver read a paper upon "The Treatment

of Appendicitis," in which he reported a large number of operations with a great number of recoveries. He took the rather advanced stand that practically every case of prolonged acute pain in the right iliac fossa was appendicular in origin, indicating the presence of an appendicitis more or less acute, and that the presence of appendicitis indicated an operation: first, because, if operated upon very early, the mortality is almost *nil;* second, because, if operation is deferred, it becomes more difficult after several attacks, and for this reason, and because attacks generally increase in severity, the danger to the patient's life is enhanced. In the early stages of the inflammation the operation may be resorted to, or, if the symptoms are not pressing, it is preferable to wait until the acute symptoms have subsided, and then to operate before another attack is superimposed upon the first. Dr. Deaver also advised the administration of a saline purgative or castor-oil in full dose in all cases of appendicitis, with the double object of removing from the bowel indigestible food which may be producing the pain, or, if operation is required, of emptying the bowel of fæcal matter.

Dr. McBurney, of New York, emphasized very strongly his opinion that medical treatment of these cases is invariably futile, and that in many instances an attempt at such treatment places the surgeon eventually at a distinct disadvantage, because of the ravages which have been produced by the disease before he has had an opportunity to operate. He disagreed, however, with Dr. Deaver as to the advisability of administering purgatives, as he did not believe that the pains of indigestion were difficult of separation from the pains of appendicitis, and did not regard the emptying of the bowel, except in extraordinary cases, as a necessary preliminary measure to operation. He asserted most emphatically that the appendix was the source of septic infection from the very beginning of appendicular inflammation; that it provided a fertile field for the growth of micro-organisms which, while benign in the healthy intestine, speedily become malignant when, by reason of pathological changes, their growth is more active. The septicæmia arising from this local point of infection varied in different individuals, according to their power of septic resistance, just as one man resists the septic infection of a severe post-mortem wound and another dies of a pin-prick while making an autopsy. For these reasons he strongly urged operation upon every appendix which seemed to be in trouble, and its removal as early as possible before the general system had become infected. Later in his remarks he admitted that he preferred, in the majority of cases, to wait twenty-four to forty-eight hours, until the acute symptoms had passed by, before operating, as the results were usually better under these circumstances, though, should symptoms become fulminating during this period, operation should not be delayed. He reiterated the statement that all medicinal means were wretched makeshifts in cases of appendicitis, and challenged any medical man present to offer a plan of treatment which could be shown to have any distinctly favorable influence upon the disease.

Dr. William Osler, of Baltimore, as a medical clinician, took the ground that too many appendices were removed, and that the operation for

appendicitis was passing through the excessive stages through which operations upon the tubes and ovaries passed a few years since. He recalled the results of a large number of post-mortem examinations made by him in which persons died of other diseases than appendicitis, but in whom evidences of appendicitis having previously existed were present, proving that acute appendicitis could occur with entire cure without operative interference.

Dr. Hare inquired of Dr. Deaver whether there was not danger in administering active purgatives to patients in whom a perforated appendix existed, on the ground that through this perforation fæcal matter might be swept out into the abdominal cavity; and he quoted a paper of Dr. McBurney's, in which that gentleman had asserted that in all his operations he had never found fæcal matter in the *caput coli*, and that for this reason the administration of a purgative was not needed.

Dr. John Ashhurst took the ground that Dr. Deaver and Dr. McBurney were far too advanced in their views in regard to operations for appendicitis. He quoted a number of cases in which he had seen active medicinal measures produce cures, and he protested, in the name of conservative surgery, against the extreme views entertained by the first two speakers, stating that, in his experience, the application of ice over the right iliac fossa and the administration of opium until the respirations dropped to twelve a minute had removed acute inflammations of the appendix in a large proportion of cases. He did not for a moment deny that operation was often needed, but he did assert that it was by no means indicated as a measure of first resort in every case.

Dr. A. V. Meigs practically agreed with Dr. Ashhurst, and, while expressing his willingness to call in a surgeon as a consultant in all cases of appendicitis, declined to admit that surgical aid was necessary in all instances.

In closing the discussion, Dr. Deaver stated that he had seen instances in which the administration of purgatives in cases of perforated appendices had resulted in the escape of fæcal matter into the peritoneal cavity.

As a result of this and other interesting discussions upon this most important topic, it would appear that the general practitioner, in many instances, will relieve himself of some responsibility if, from an early stage of the disease, he call to his aid in diagnosis a surgical consultant, who will be called in not to operate, but to watch the case from a surgical standpoint, to determine at its various stages whether an operation is necessary. A surgeon should be chosen who is neither ultra-radical nor ultra-conservative, who will neither urge operation too soon nor postpone it too late; and he should be a man who, while skilled in surgery, has enough regard for the opinion of the medical clinician to permit his own judgment to be influenced by medical opinions, should good reasons be adduced why an operation should not be done; for it is evident that a time is rapidly approaching when the operation for appendicitis will not be so frequently performed.

It is also evident that cases of appendicitis may be divided into three classes: those which are fulminating or gangrenous from the moment of

their invasion, and which in the majority of cases are fatal whether operated upon or not; second, those in which medicinal measures or measures applicable by a medical man, such as the application of cold and leeches and opium, are to be tried, and, these failing, operation resorted to soon or late, according to the rapidity of development of the attack; and, third, those cases of appendicitis which, with perfect safety and entire cure, may remain untouched by the knife, and in which purely medical measures bring about the results desired.

While an attack of appendicitis may predispose a patient to subsequent attacks, operations to avoid attacks cannot be considered as advisable, since they simply deal with the possibilities and not certainties of the future, and it is only after a man has had one severe or several rapidly succeeding attacks of appendicitis that an operation should be resorted to during the period of quiescence as a prophylactic measure.

An interesting part of the discussion was the statement by Dr. S. Weir Mitchell that in some cases of appendicitis post-operative neuroses or other nervous complications sometimes occur, and that he knew of a case, or cases, in which, following operation, the pain and discomfort in the abdomen were so excessive as to incapacitate the patient from all employment and to render the remedy worse than the disease.

Dr. Deaver also called attention to the fact that the removal of a chronically diseased appendix relieved chronic intestinal dyspepsia and diarrhœa in many cases,—a fact first insisted upon by Dr. J. H. Musser, of Philadelphia.— *Therapeutic Gazette*, December 15, 1894.

Southern Surgical and Gynæcological Association, Charleston, S. C.

Varicocele Treated by Incision, Ligation, and Shortening of the Scrotum. —Dr. W. E. Parker, of New Orleans, reported seven cases of this affection thus treated. An incision varying in length according to the size of the varicocele is made, and the scrotum shortened by converting the wound from a longitudinal into a transverse one. All cases which recovered with union by first intention are still doing well, the period since the first operation being seven months. The milder form of varicocele should be treated with a suspensory bandage, proper attention being given to diet, exercise, and bowels. A varicocele should be operated upon: (1) if it is of large size; (2) if it is painful; (3) if marked nervous symptoms are present; (4) if the testicle is atrophying; (5) if the varicocele is increasing rapidly; (6) if it is an obstacle to entering a public service; (7) if, on account of a patient's occupation a suspensory is troublesome, and he desires an operation.—*Boston Medical and Surgical Journal*, December 27, 1894.

The Removal of an Intra-uterine Fibroid Tumor by Morcellement without Hæmorrhage.—Dr. Herbert M. Nash, of Norfolk, Va., read a short paper on this subject. In September, 1892, he saw in consultation Mrs. A., aged 42, the subject of intractable hæmorrhages from the uterus, lasting from two to three weeks of each month, and which had been habitual for several years. The uterus could be plainly felt above the pubes, and by

the conjoined method, sound, etc., the diagnosis of intra-uterine fibroid was made. Not wishing at that time any radical procedure, she continued under the care of her physician, whose best efforts to control the hæmorrhage proved fruitless. On July 11, 1893, she entered the hospital for surgical treatment.

On August 26th Dr. Nash operated under ether. It was found quite impossible to dilate the os to the extent desired, but there was room enough for the manipulation without dividing the cervix, and no difficulty was found in seizing the presenting mass—the attachment of which to the uterine walls had been made out to be sessile—with a strong vulsellum. Upon making traction with some force, in order to determine the best method of procedure, the tissue gave way, and the withdrawn part of the detached mass was quite large, but no bleeding followed. This fact decided him to proceed by morcellement, and with forceps, scissors, and the instrument which he exhibited, the whole growth was removed piecemeal, and with only a slightly-colored serous discharge. The previous packing had been so effectual that the growth itself, and indeed the uterine walls, appeared to have been exsanguinated. The fragments removed, when under strong compression, presented a mass of fibroid tissue nearly as large as an ordinary cocoa-nut. When the patient left the hospital the uterus had contracted firmly, and measured a fraction over three and one-half inches in depth, occupied its proper position in the pelvis, and the patient is to-day entirely well, with perfectly-normal functions.—*Medical Record*, December 22, 1894.

Medical and Chirurgical Faculty of Maryland.

Chills as a Cause of Error in Diagnosis.—Dr. William Osler made some remarks upon this subject. Chills differ very much in their etiology, but may be divided into two main groups: (1) those from sudden shock to the nervous system, and (2) those from absorption of the toxic material formed by organisms. In so-called nervous chill fever is absent. In the second group there is always fever. The nervous chill is that met with in gall-stone colic or in the passage of a catheter. This initial chill is without fever, but subsequently, of course, there may be chills with fever due to infection. The disease most often associated with chills is malarial fever, and here the chill is of a characteristic kind; so that the name "chills and fever" is synonymous with malaria. The two great diagnostic points in malaria are the invariable association of the plasmodium of Laveran and the invariable curative effects of quinine. It may be said that within forty-eight hours the chill will cease in genuine malaria if quinine be used.

Chills cause errors in diagnosis in various affections. In tuberculosis the error may be made early or late in the disease, for it is at the two extremes of pulmonary tuberculosis that we have chills. These are a special feature of the early stages of tuberculosis. He has had many cases of early phthisis brought to him as malarial fever. Errors occur frequently in regions where paludism is common. Then there is the large group of septic

processes with fever, such as abscess of the liver, which is a common cause of chills and fever in this latitude. There are very few cases of abscess of the liver which are not at first regarded as malarial fever, and thus much valuable time is lost in the treatment. Malignant endocarditis is another disease which is ushered in by chills and which is often treated for malaria. A not frequent source of error is the chill following and associated with pleurisy of a tuberculous form and empyema following the infectious diseases, as scarlet fever, etc., and following the formation of pus. The chills in typhoid fever are of the greatest importance, and have attracted attention for years. They occur in 2 or 3 per cent. of all cases, and are often due to the powerful antipyretics given. He had seen cases in which chills and fever had followed a large dose of antifebrin. In certain affections of the urinary passages, and more especially in pyelitis, chills occur which are often obscure. In chronic obstruction of the common duct by gall-stones there is the condition called by Charcot hepatic intermittent fever due to catarrhal cholangitis. In new growths of various kinds, as in cancer of the stomach, in Hodgkin's disease, and lastly in syphilis, errors as to the nature of the fever may be made. The important aids in the diagnosis of chills are quinine and the examination of the blood.—*Medical Record*, January 12, 1895.

Selections from Reports of Members of the Annual's Staff of Correspondents.

Japan.

DR. W. N. WHITNEY,

CORRESPONDING EDITOR FOR MEDICAL LITERATURE OF JAPAN.

All books, theses, monographs, etc., published in Japan should be sent to

DR. W. N. WHITNEY,
U. S. Legation,
Tokyo, Japan.

Physique of Japanese and Chinese Troops.—DR. ISHIGURO, President of the Field Medical Department of Japan, recently ordered the chief surgeons of the garrisons where the Chinese prisoners are lodged to make physical examination of the prisoners under their care. On comparing the figures with those of the Japanese troops (though only some 70-odd Chinese were examined, and decisive statements cannot be made) it may be safely said that the Japanese troops are in many respects superior, because the Chinese troops are not selected as in Japan, by scientific physical examination. Hence, though there are in Chinese armies such fine men as are not to be found in Japanese armies, still, taken as a body, their average figures are inferior to the Japanese. From the accompanying table the service done by sanitary science in the production of strong men will be evident to all:—

	Japanese.	Chinese.	Chinese Compared with Japanese.
Age	21 years 5 months.	29 years 10 months.	8 years 5 months older.
Height	5.44 feet.	5.50 feet.	0.06 foot higher.
Weight	135 33 pounds.	121 8 pounds.	13 8 pounds lighter.
Around the chest	2 81 feet	2 96 feet.	0.15 foot larger.
Difference in respiration	0 232 foot.	0.221 foot	0 011 foot less.
Lung-capacity	3631 cubic centimetres.	3129 cubic centimetres.	502 cubic centimetres less.
Dynamometer	41 kilogrammes.	31 kilogrammes.	10 kilogrammes less.

The Japanese figures represent the average of 14,218 men taken after a year's service. The Chinese figures are the result of the examination of 77 healthy prisoners. These men had been in service for periods ranging from three months to thirty years; and the oldest of them was 55 years, while the youngest was 16.

Poland.

DR. C. SZADEK,

Redactor Korespondent z działu polskiej literatury tyczącej się: Chirurgii ogólnej; dermatologii; syphilografii; chorób chirurgicznych (tężec, wodowstręt, itd.).

Wszystkie pisma lekarskie, dzieła, rosprawy, monografije, itd., w języku polskim wydane, a tyczące się przedmiotów powyższych, winny być nadsyłane pod adresem

DRA. C. SZADKA,
2, Ulica Teatratna,
Kijów,
Rossyja.

Subconjunctival Injections of Corrosive Sublimate in Ocular Disease.—LANGIC has had satisfactory results from repeated injections of corrosive sublimate in many cases of corneal ulcers with hypopyon, parenchymatous keratitis, infected injuries of the cornea, gummous iritis, iridocyclitis, affections of the vitreous, retinitis, and sympathetic ophthalmia. The method is contra-indicated in retinitis pigmentosa, optic-nerve atrophy, conjunctival and choroidal affections. The author used a solution of 1 to 2000, making the injections sometimes daily, sometims only every five days, preceding them by the application of a 5-per-cent. solution of cocaine. He also carried out at the same time an appropriate general treatment.—*Przeglad Lekarski*, Nos. 28–36, 1894.

MUTTERMILCH also obtained very successful results from the use of these injections in five cases of hypopyon, traumatic iritis, and sympathetic ophthalmia. —*Gazeta Lekarska.*

Chancroid of the Finger with Bubo of the Right Ulnar Lymphatic Gland.—KOPYTOWSKI describes a rare case of chancroid of the outer surface of a finger on the right hand. The ulnar gland was enlarged and painful on pressure, and the cuticle became red. The ulcer cicatrized after local treatment with iodoform, and the bubo yielded to applications of iodine and compresses.—*Kronika Lekarska*, September, 1894.

Iodine in the Treatment of Syphilis.—SZADEK, in a lengthy monograph on this subject, expresses the opinion that iodine exerts an action not upon the syphilitic virus, but upon the syphilitic toxin products. He gives the indications and contra-indications for the use of the various iodine preparations, and states that he has tried iodol in a number of cases with very

good results. He gave daily doses of 2 to 4 grammes (31 to 62 grains). The remedy was well borne, and the author considers it as a useful substitute for iodide of potassium.

Syphilitic Infection of the Mother by the Fœtus.—At the meeting of the Polish Medical Congress in Lwow, SZADEK endeavored to refute the theory that the syphilitic fœtus may infect the mother. An examination of the mother in such cases shows that the lesions are not so recent as if the disease were acquired from the fœtus. No facts have been brought forward to prove that solid substances or formed elements can pass from the fœtus through the placenta into the maternal circulation; and, as at the present time it is admitted that syphilis can be transmitted only through the medium of formed elements, it is highly improbable, in his opinion, that the child in the womb can communicate the disease to its mother.

Russia.

DR. J. DRZEWIECKI,

РЕДАКТОР-КОРРЕСПОНДЕНТ изъ области русской литературы, касающейся: Общей медицины и терапіи, педіатріи, акушерства, гинекологіи, дерматологіи, отологіи, гигіены, демографіи, судебной медицины, гистологіи, бактеріологіи, анатоміи и физіологіи.

Всѣ періодическія, медицинскія изданія, сочиненія, стат'и, монографіи и т д., изданныя на русскомъ языкѣ и касающіяся вышепоименованныхъ предметовъ должны быть адресованы на имя

ДРА ДРЖЕВЕЦКАГО.

87 Краковское Предмѣст'е,

Варшава.

The Effect of Food on the Absorption of Drugs.—TH. P. MALININ, in a study of the absorption of various medicaments in the empty and full stomach, came to the conclusion that absorption was very rapid when the stomach was empty, and that when food had been taken it was much slower. In one case it did not occur for eighty-five minutes, and in another for two hundred and fifteen minutes. Hydroiodide of potassium appeared in the saliva and urine either at the same time or three to five minutes earlier in the former, the excretion in both ceasing at the same period. This is probably due to the unequal action of the kidneys in different individuals. Sodium salicylate cannot be discovered in the urine by the ferrum sesquichloratum test. From the experiments of the author it appears that the excretion of medicinal substances corresponds to the rapidity of their absorption. The delay in absorption after a full meal is due to the mixing of the substances with the food and their separation from the stomach-walls, rather than to the increased blood-pressure in the organ incident to digestion.—*Vratsch*, No. 37, 1894.

Disinfection of Tuberculous Sputum.—G. T. GORIANSKI, in an inaugural thesis, based upon his studies in the Institute of Experimental Medicine at St. Petersburg, states that pyroligneous acid, mixed in equal quantities with the sputum, will completely disinfect it, destroying the tubercle bacillus in six hours, and all streptococci and staphylococi that may be present in three hours. A 10-per-cent. alkaline solution of pine-tar, in equal quantity, kills the tubercle bacillus in forty-eight hours, and a 25-per-cent. solution in twenty-four hours. A few experiments made with lysol in 10-per-

cent. solution, and carbolic acid in 5-per-cent. solution, showed these agents to be effective in twenty-four hours.

Effect of Cognac on the Assimilation of Fat and Nitrogen.—SHENDRIKOWSKI and DOMBROWSKI occupied themselves with this subject in the clinic of Professor Chudnovsky in St. Petersburg, experimenting on healthy individuals submitted to a milk diet. The body-weight was found to increase 370 grammes (12 ounces). The daily quantity of urine diminished to 657 cubic centimetres (1¼ pints); the assimilation of nitrogen decreased 0.2 per cent., the metabolism of nitrogen 5.5 per cent.; fat assimilation increased 1.26 per cent.; the proportion of water excreted as compared to that ingested increased 4.2 per cent.; the losses through skin and lungs increased 1474 grammes (3 pints).—*Vratsch*, No. 41, 1894.

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Sweden.

DR. F. EKLUND,
Brefväxlande Medarbetare för den
SVENSK MEDICINSK LITTERATUR.

Af alla i Sverge utkommande medicinska tidskrifter, bocker, afhandligar, monographier a. s. v. torde ett exemplar benäget öfversändas till

DR. ABRAHAM FREDRIK EKLUND,
Sibyllegatan, 3 A,
Stockholm.

The Horns of Ammon in Epilepsy.—In his thesis for the doctorate in medicine in Lund University, NENANDER gives a detailed account of his examination of Ammon's horns in three cases of epilepsy and one case of idiocy with epileptic attacks. In the first case, most interesting from an histological stand-point, Ammon's horn on the left side appeared normal macroscopically, but microscopically was found to be the seat of morbid alterations. The right horn showed the same alterations, but visible to the naked eye. The difference in size between the two was considerable; the breadth of the stratum of nerve-cells, for example, being 120 millimetres in the left and 100 millimetres in the right, while the length of the latter was diminished at least one-half. The rim of the fascia dentata, at its usual point of union with the subiculum, was almost entirely free.

In the second case microscopical examination showed in many places, as on the lower side of the gyrus hippocampus and the adjacent convolution, a thickening of the pia and marked alteration of the superficial layer of the neuroglia, the fibrils of which were longer and thicker than normal and the nuclei increased in number. The stratum of nerve-cells in the left horn was considerably thinner and less supplied with nerve-elements than that on the right side.

In the third case the changes were particularly marked in the fascia dentata and in the nerve-cells of the left horn, the stratum being half as wide as on the right side. In the fourth case the ball-shaped, swollen anterior extremity of the right horn was twenty millimetres in breadth, that on the left eighteen millimetres. A condition of atrophic degeneration of the under portion was observed. The alterations in the brain-substance consisted principally of limited proliferation of the neuroglia, breaking down of ganglion-cells and myelin-fibrils, and the formation of cavities between. There was in several places a tightening of the adventitia of

the blood-vessels, a hyaline degeneration of the walls of the smaller vessels, with narrowing of their lumen or diminution of the number of capillaries. The author comes to the conclusion that, as Holm has already stated, alterations in the cornua of Ammon may more frequently be observed in individvals not suffering from epilepsy than has hitherto been supposed.

Nephrectomy and Ureterectomy.—CHARLES SCHILLER describes the case of an unmarried woman, 26 years of age, who suffered from diffuse pains in the abdomen, strangury, and cloudy urine without blood, calculi, or gravel. The patient was greatly emaciated and feeble, with anorexia and dyspnœa. Albumin appeared later in the urine; the right kidney was considerably swollen, round, firm, and without any elevations. The author made a sacro-lumbar and transverse incision, giving exit to a large quantity of thin pus and caseous masses. He then extirpated the kidney and washed out the wound-cavity with warm salt solution. He also resected the ureter at the pelvic border. The renal pelvis and ureter were filled with tubercles, some partially broken up and in a state of caseous degeneration. The kidney removed was nineteen centimetres long, nine centimetres broad, and twelve centimetres in thickness, and consisted of a mass of cavities of varying size filled with thin, caseous pus. During convalescence the urine increased from 400 to 1000 grammes ($\frac{4}{5}$ to 2 pints).—*Lakäresallskaps forhändlingar*, p. 110, 1894.

Laparotomy in an Infant.—A. LINDH was called upon to treat a child of 5 months suffering from vomiting and exhaustion. No fæces were passed, but considerable blood was discharged through the anus after enemata were administered. The abdomen was soft, but not tender. The patient cried incessantly. Upon opening the abdomen, invagination of the ileum and colon as far as the descending colon was found, and reposition effected after some manipulation. There were no adhesions. Fæces were immediately passed after the administration of clysters, and recovery took place rapidly, though gangrene occurred on one of the borders of the incision.—*Lakäresallskaps forhändlingar*, p. 19, 1894.

Chronic Icterus from Compression of the Lymphatic Glands.—H. KÖSTER had under his care a boy, 3 years old, who suffered from repeated attacks of vomiting and jaundice of varying intensity from the age of 14 months. The appetite, previously good, was lost, and the child was greatly emaciated and complained of severe cramps in the lower extremities. The abdomen was much distended. The mother was phthisical. The condition of the child gradually grew worse: the temperature rose, dyspnœa supervened with vomiting every day, and he whined constantly. Inflammation of the right lung occurred, and the liver, which was exceedingly sensitive, increased in size. The icteric color of the skin gradually disappeared and the temperature fell to normal, but marasmus developed, followed by death. Post-mortem examination showed tuberculosis of the lungs and spleen, some hypertrophy of the connective tissue of the liver, and considerable dilatation of the biliary ducts. A great number of tubercles as large as a pea, and many of them caseous, were disseminated throughout the liver. The

portal hepatic glands were swollen to the size of a bean, and the mesenteric glands were also swollen. In the lowest part of the ductus choledochus a perforation of the wall, some few millimetres in diameter, led down to a cavity the size of a hazel-nut, filled with a stieky, puriform mass, and surrounded by a fibrous and rather firm capsule of connective tissue.—*Lakäresallskaps forhändlingar*, p. 6, 1894.

Clinical Notes.

The Dreams of the Blind.—Dr. William W. Ireland gives an interesting *résumé*, in the *Journal of Mental Science* for January, of an article upon this subject by Friedrich Hitschmann, appearing in the *Zeitschrift für Psychologie und Physiologie der Sinnesorgane*. Mr. Hitschmann became blind in the third year of his life, but is still able to distinguish between light and darkness. He never dreams of seeing, and does not share the fancy of the poets that the spirit, freed during sleep from bodily restraint, can realize the gift of sight. He tells us that the blind, in general, have weaned themselves from their deficiency, and feel themselves in an accustomed and natural condition. They have not that painful longing for light which those who have all their senses sometimes poetically ascribe to them. Naturally their dreams are compounded of the other sensations, especially the impressions of hearing. The blind dream much of voices, by which the persons of their acquaintance are recognized, whereas the seeing often dream of faces and figures; sometimes animals, especially dogs and birds, seem to the sightless to have human voices, and to be gifted with speech. A blind man who traveled home once a year used to dream of the journey by rail. In this case the dreams were made up of the lumbering of the wheels, the whistle of the locomotive, the feeling of fresh air through the open windows, and the smell of food sold at the station.

Mr. Hitschmann tells us that, while the dream-world of the blind is poor in sensory images, it is rich in abstract phenomena. It is characteristic of their dreams that the sleeper often feels himself a spectator as if he witnessed a play in a theatre. He seems to witness novels, dramas, or philosophical lectures. It is supposed that these appear to come through the rea, for he tells us that he never dreams of handling a book for the blind, or of using his writing apparatus. Seeing people, however, seldom dream of reading and scarcely ever of writing.

The Morbid Anatomy of the Lungs After Influenza.—Louis B. Hayne, of St. George's Hospital, London, discusses the various pathological changes visible to the naked eye in the lungs of victims to the recent epidemics of influenza. The mortality of influenza seems to be mainly due to involvement of the lungs, the deaths from the virulence of the febrile attack and from implication of the digestive tract being comparatively few. These pulmonary complications were not only fatal to the young and the aged,

but also to adults in the prime of life, death generally occurring about the tenth day after the onset of the attack.

In the cases of pneumonia occurring in influenza, the peculiar smooth aspect of the consolidated lung noted by Ribbert (*Lancet*, vol. i, p. 1318, 1892) has been frequently observed in the deaths from recent epidemics, alone as well as with associated areas of broncho-pneumonia. The solid lung often appears to be composed of a number of patches of broncho-pneumonic consolidation, these patches having run together and involved the entire lung, suggesting the appearance of a confluent broncho-pneumonia rather than that of the croupous variety of pneumonia. Some lungs, on the other hand, show the results of ordinary lobular pneumonia, this condition being observed in early adult life quite as frequently as in youth or old age. Broncho-pneumonia, rare under ordinary circumstances in an adult, except cases of septic origin, is by no means uncommon as a complication of influenza, but the confluent type just referred to is even still more common. This is often found in the same lung in conjunction with a red hepatization, the gray, isolated patches of consolidated lung-tissue around a small bronchus contrasting very plainly with the uniform red and congested appearance of the remaining tissue. These patches often seem to originate in the posterior borders, and thence to spread to the apices and sides, so as eventually to involve the whole lobe. In other cases the apices are the parts first affected, apical pneumonia being more frequent than any other condition in influenza.

In some cases pale patches of broncho-pneumonia have been found scattered throughout the lung, suggesting at first sight tubercle of the miliary type. Under the microscope the small bronchi are seen filled with fibrinous plugs; the cells lining the bronchi have undergone proliferation, some having escaped into the lumen of the tube; the alveoli in the neighborhood are crowded with catarrhal cells, and the blood-vessels in the surrounding tissue are dilated and crowded with corpuscles, some of which appear to have escaped from the vessel-walls into the pulmonic substance. These patches are distinct around each bronchiole, but run into one another at the periphery. The distribution is thus broncho-pneumonic, while the character of the exudation resembles that met with in lobar pneumonia. As in broncho-pneumonia, the localized patches of consolidation are accompanied with collapse of the neighboring lung-tissue, due to a similar cause, viz., the blocking up of the bronchioles with exudation and the consequent removal of the air from the alveoli in communication with the bronchioles at fault.

Localized patches of pleurisy, characterized by the adherence of the pleural surfaces to each other by means of recent lymph, are also frequently present, and arise from an extension of the inflammation from the superficial patches of consolidated lung-tissue. Pleural effusion is rare, not one case being found among the records of post-mortem examinations at St. George's Hospital during the recent epidemics of influenza.

Besides the capillary bronchitis, which generally terminates fatally, inflammation of the larger tubes is very common. The bronchi are found to be congested, their inner walls often being covered with thick, tenacious

mucus; as a rule, the larger tubes are not so deeply congested as the smaller ones. They are usually filled with muco-pus, and in some cases are so distended with purulent secretion that on being cut across they look exactly like small abscesses, varying from the size of a pea to that of a pin's head. The whole thickness of the bronchial wall is considerably softened, accounting for the dilatation of the tubes so often present. Occasionally the walls are so dilated that a condition of acute bronchiectasis is simulated. The dilatation involves the whole length of the tube, but more markedly its terminations, being thus of the cylindrical variety. Clinically, however, the typical symptoms of bronchiectasis are not manifested, though the expectoration may be very profuse. The contents of the tubes are not always muco-purulent in character, but are sometimes quite fibrinous or membranous.

In most cases there is present not one of the conditions just described, but a number of them. One lobe may be in a state of solid, gray hepatization, another may be studded with disseminated patches of consolidation of varying sizes, while at the same time the bronchial tubes may present any of the morbid conditions above noted.—*Practitioner*, October, 1894.

Abortion.—Recognizing that any interference with the uterine cavity must be looked upon as a possible source of danger, and, to be free from this danger, must be made aseptically and with antiseptic precautions, Dr. Brooks H. Wells, of New York, strongly urges that, in every case where abortion or miscarriage begins acutely and from natural causes, the ovum be removed by the finger, ovum-forceps, or curette, within twenty-four hours after the abortion be considered inevitable, if the entire ovum be not then already expelled, complete expulsion being usually indicated by cessation of pain and hæmorrhage. In cases where a portion has been expelled; where there is serious hæmorrhage; where the ovum is dead; where there is reason to suspect criminal interference; where there has been continual spotting, foul discharge, or fever, the uterus should be explored and emptied at once, as any delay greatly increases the risk of sepsis. The sharp irrigating curette, followed by gauze drainage, should always be used where there is septic material present or where the endometrium is diseased; in other conditions the finger or a dull instrument is sufficient.—*Medical Record*, September 22, 1894.

Vulvo-Vaginal Cyst.—Dr. A. F. House, of Cleveland, operated upon a rare case of vulvo-vaginal cyst, the patient being 58 years old. She first noticed an enlargement of the left labium in her twenty-sixth year, the size remaining stationary until the occurrence of the catamenia at 45 years, when the growth reached the size of a small teacup. It remained so for a number of years, when it again began to grow, reaching the enormous size of seventeen and one-half inches in circumference in its long axis and fifteen and one-half in its short axis. It measured sixteen inches in circumference at its attachment, extending from the upper margin of the os pubis to the anus, its main support being from the ascending ramus of the ischium. An incision was made from the upper margin of the os pubis downward about two inches, extending on either side of the tumor to the anus, thus encir-

cling the growth. The lateral flaps were then dissected up, and the entire cyst-wall and the labia majora and minora and the clitoris were removed by the knife and scissors. The parts were extremely vascular, requiring the ligation of a large number of vessels. Its contents were of a thin, muddy appearance. The wound was united by carbolized silk sutures, and dressed with iodoform gauze. On the seventh day the sutures were removed, and the patient was discharged from hospital on the fourteenth day. —*Cleveland Medical Gazette*, September, 1894.

Tuberculin in the Diagnosis of Bovine Tuberculosis.—Dr. E. P. Niles, of Blacksburg, Va., from personal experiments with tuberculin, finds that it is the only means whereby tuberculosis can be diagnosed in animals. Physical examination may show well-marked cases of the disease in a dairy or herd, but the latent forms cannot possibly be thus detected. With tuberculin properly used, however, it is possible to detect tuberculosis early enough to eradicate it, and thus make the milk of cows so affected comparatively safe for man and animals dependent upon a fluid diet.—*Virginia Medical Monthly*, September, 1894.

Gastrostomy for Stricture of the Œsophagus.—In a consideration of the recent methods of gastrostomy, Prof. Willy Meyer, of New York, states that there are now three useful and reliable methods at the surgeon's disposal. Of these, Witzel's method prevents leakage with absolute certainty, and the other two, if properly carried out, promise the same good result. The patient need not, therefore, suffer from regurgitation of the food alongside the tube. The operation should be resorted to early in cases that will sooner or later require it. In burns of the œsophagus, primary gastrostomy and dilatation of the contracting scar will most probably prevent conditions that at present generally confront the surgeon and are incurable. Witzel's method is preferable, as the oblique canal produced by it will close spontaneously when the tube is removed, and a secondary operation will be unnecessary. In cases of cancer of the œsophagus, a gastric fistula should be established as soon as the scales show a steady decrease in the patient's weight. Sabanejew-Frank's method seems destined to become the standard one for malignant stricture of the œsophagus, though further experience is needed to establish its position. Von Hacker's method should be reserved for far-gone patients, and if the patient be very weak it should be done under cocaine anæsthesia, preferably in two sittings.—*American Journal of the Medical Sciences*, October, 1894.

Indolence of the Cæcum in Children.—Dr. Jules Simon, in a clinical lecture, calls attention to this condition as occurring in children of sufficient age to be left considerably to themselves. They eat in a careless manner, and frequently eat too much. The food remains in the cæcum and large intestine, giving rise to such symptoms as headache, incapacity for study, paleness, and irregular and capricious appetite. Although there is a daily movement of the bowels, this is not sufficient, and the cæcum and colon, on palpation, will usually be found sensitive and engorged. In such cases, M. Simon employs a symptomatic treatment against the constipation, and

hygienic and preventive measures against the return of the trouble. Every morning he gives sweet almond-oil, 15 grammes (3¾ fluidrachms); castor-oil, 20 to 30 drops; or a tablespoonful of syrup of rhubarb in water; or an infusion of senna-leaves in coffee or chocolate with milk.

Before the two principal meals he gives a pill containing 0.01 gramme (⅙ grain) each of extract of hyoscyamus and powdered hyoscyamus, and after the meal an elixir or a cachet composed of cream of tartar, 0.10 to 0.15 gramme (1¾ to 2¼ grains); vegetable charcoal, 0.05 to 0.10 gramme (⅞ to 1¾ grains); calcined magnesia, 0.20 gramme (3 grains). There are cases in which this treatment fails, and it becomes necessary to substitute half a glass of a natural laxative mineral water, returning later to the above prescriptions, or giving cascara or magnesia. The most important point is to prevent alternating diarrhœa and constipation.

As external treatment, friction and massage of the abdomen and continued electric currents, if necessary, are employed, and, if there is any congestion of the cæcum or pericæcal ganglia, the parts are painted with tincture of iodine or small vesicatories applied.

Dr. Simon believes the diet to be of great importance, and advises that no solid foods be taken, but that meats, fish, etc., be reduced to a fine pulp, and vegetables be given in the form of a *purée*.—*Journal des Praticiens*, January 19, 1895.

Monosulphide of Sodium in Lead Poisoning.—J. Peyrou, of Paris, having obtained excellent results from the use of monosulphide of sodium in the treatment of lead poisoning in animals, applied the method to twenty cases at the Hôtel-Dieu, the St. Louis Hospital, and the Paris Polyclinic. The eliminative power of the drug was invariably manifested, as shown by an examination of the urine before, during, and after the treatment. The fæces were also colored at the beginning of the treatment, gradually resuming a normal aspect, thus showing that the sulphide of lead was eliminated by the intestines. The pain in lead colic disappeared rapidly in every case. Paralyses were more rebellious, which is not surprising, as the modifications of the nerve-tissue due to the presence of lead in the organism would naturally persist for some time after the elimination of the lead. Sulphide of sodium evidently acts only as an eliminating agent, but it also favors the return of the tissues to a normal state. However, paralysis yielded to the treatment rapidly enough, especially when associated with electricity.

That sulphide of sodium may also be of value as a prophylactic in such cases was shown by one instance in which the patient, recognizing from the symptoms that he was about to have a recurrence of the paralytic attack, had recourse to the use of the drug, as recommended, when all the symptoms disappeared. It is also of use in the diagnosis, as it invariably causes an elimination of lead by the urine in cases of lead poisoning. This is of some importance from a medico-legal stand-point, as it is not uncommon for workmen to demand damages from their employers for simulated lead colic. The dose given by the author is from 0.30 to 0.40 gramme (4½ to 6 grains) of monosulphide of sodium dissolved in glycerin in two doses daily. This

is kept up as long as fifteen days if necessary.—*Annales de la Policlinique de Paris*, December, 1894.

Salophen.—This analgesic is recommended by LARRAND as being fully as valuable in rheumatism as salicylate of sodium, while it does not provoke the same headache, tinnitus aurium, or feeling of intoxication. It does not affect gastric digestion or give rise to nausea, as it does not decompose except in an alkaline medium (the intestine). The taste is insipid and not disagreeable. The average dose is 2 grammes (31 grains) daily, divided in four doses.—*Jour. des Sciences Méd. de Lille*, December 22, 1894.

Phenolates of Mercury.—E. DESESQUELLES finds that the phenolates of mercury and some of their derivatives have an antiseptic power somewhat feebler than that of bichloride of mercury, and inferior toxic properties. They may, therefore, be of great service in certain infectious diseases, but, unfortunately, they are but slightly soluble in water and require especial care in their preparation.—*Revue Inter. de Méd. et de Chir. Prat.*, December 25, 1894.

Guaiacol.—BRILL has investigated, in Unverricht's clinic, the effects of external applications of guaiacol, and concludes that doses of 1.5 to 3 cubic centimetres (23¼ to 46 grains) are efficient as an antipyretic, but that the untoward symptoms caused by such doses are such as to render its use undesirable. Doses of 0.75 to 1.5 cubic centimetres (11⅝ to 23¼ minims) are without such effects, and possess an antineuralgic action in a number of diseases.—*Cent. f. Innere Med.*, November 24, 1894.

Bicarbonate of Sodium in Gastric Diseases.—PROFESSOR DUJARDIN-BEAUMETZ has studied the effect of this agent upon the gastric secretion, without reference to its effect upon the motility of the stomach, upon gastric and intestinal fermentation, or its analgesic properties. His conclusions, based upon experimental as well as clinical observation, explain in a logical manner its paradoxical but undeniable action upon two opposite conditions of the stomach. According to him, the drug acts upon the gastric secretion first by exciting and then by depressing it. The excitation is due to the immediate effect upon the gastric glands, while the depressions seem to be due to its general effect, or, in more exact terms, to the alkalinization of the blood. In practice, moderate doses must be used when it is desired to obtain the excitant action, given before meals, and for a short period only. To obtain the sedative effect, large doses, before or during meals, should be continued for some time. The exact size of the dose cannot be absolutely specified, as this depends upon the state of the gastric secretion, the susceptibility of the stomach to bicarbonate of sodium being in inverse ratio to the quantity of hydrochloric acid secreted. These conclusions apply also to Vichy and other waters containing bicarbonate of sodium.—*Bull. Gén. de Thér.*, December 15, 1894.

Albuminuria of Pregnancy.—Preventive and curative treatment: Milk diet; absolute repose, if possible; no traveling; no drugs. (HENRI HUCHARD *Journal des Praticiens*, January 5, 1895.)

Recent Suggestions in Therapeutics.

Accidental Hæmorrhage in Labor.—When the os is small and labor-pains weak or absent, preserve the membranes intact as long as possible; in external hæmorrhage plug the vagina. If labor is well advanced rupture the membranes, and if hæmorrhage continue deliver by the safest method available. In internal concealed and in some cases of external hæmorrhage, if a vital necessity, deliver by *accouchement forcé* or Porro's operation. In all cases proceed with as little force and precipitation as possible. (W. J. SMYLY, *British Medical Journal*, January 12, 1895.)

Acne.—Apply several times daily *spirit. sapon. kalin.*, a few drops on a piece of flannel which has been previously moistened with lukewarm water. Dry the face thoroughly and apply 8-per-cent. *resorcin-paste*, using both day and night. If necessary, give tonics to improve general health, such as *quinine* and *hypophosphites*. (REGENSBURGER, *Pacific Medical Journal*, December, 1894.)

Acute Catarrh.—*Sulphanilic (paranalinosulphonic) acid*, 10 grammes (2½ drachms); *bicarbonate of soda*, 8.5 grammes (2⅛ drachms); *distilled water*, 200 grammes (6½ fluidounces). Give 40 to 80 grammes (1¼ to 2½ fluidounces) daily, if necessary. No untoward effects even when used for weeks. In doses of 2 to 4 grammes (½ to 1 drachm) of the acid, action manifested within two hours, persisting twenty-four to forty-eight hours, when dose should be renewed. (VALENTIN, *Nouveaux Remèdes*, November 24, 1894.)

Antiseptic Dentifrice.—*Thymol*, 0.3 gramme (4½ grains); *extract of cochlearia*, *compound tincture of melissa*, each 30 grammes (1 fluidounce); *tincture of ratanhia*, 10 grammes (2½ fluidrachms); *essence of caryophyllus*, 1 gramme (15½ minims); *essence of menthol*, 0.3 gramme (4½ minims). Use 3 drops in a quarter of a glass of water. (SCHLEICHER, *Med. Chir. Rundschau*, December 15, 1894.)

Blennorrhagic Urethritis.—*Citric acid*, 1 gramme (15½ grains); *water*, 100 grammes (3¼ fluidounces). Give in 6 injections daily. Recovery will follow on eighth day. Or, for lavage use 8 grammes (2 drachms) of *citric acid* to 1000 grammes (1 quart) of water once daily. Recovery occurs on the fifth day at latest. Tried by the author in fifteen cases without a failure and without orchitis appearing in any. (PELLISSIER, Fargu-Jiu, Roumania, *Bull. Gén. de Thérapeutique*, December 15, 1894.)

Cocaine in Labor.—Dip the forefinger in a freshly-prepared *ointment of cocaine* 1 part, in *anhydrous lanolin* 2 parts, and anoint the internal os. When this is too high to reach with ease, pass a speculum and insert the ointment. Douche with hot boric solution before applying ointment. (G. H. R. DABBS, *British Medical Journal*, December 22, 1894.)

Eczema.—*Oxide of zinc*, 2 ounces (62 grammes); *boric acid*, 1 ounce (31 grammes); *subnitrate of bismuth*, ½ ounce (16 grammes); *olive-oil* to 12 ounces (373 grammes). Use as a lotion. Give *arsenic* internally when inflammatory symptoms have subsided. Successful in a con-

siderable number of cases. In one case, in which it failed, the application of *camphoid ichthyol* to the affected parts brought about a cure in a couple of months. (J. K. TOMORY, Caithness, *Lancet*, December 22, 1894.)

Estimation of Hydrochloric Acid in Gastric Disease.—Treat 5 to 20 cubic centimetres ($1\frac{1}{4}$ to 5 fluidrachms) of stomach-contents with *barium carbonate*, thus converting the latter into *barium chloride*, to which add a slight excess of *ammonium monochromate*. Treat the resulting *barium chromate* with *hydrogen peroxide* and *dilute sulphuric acid*, and measure the amount of *oxygen*, one atom of which equals half a molecule of *hydrochloric acid*. Wagner's azotometer was used by the author, corrections being made by means of a table for atmospheric pressure and temperature. (MIERZYNSKI, *Cent. f. Innere Med.*, November 17, 1894.)

Guaiacol.—Recommended in pultaceous angina, phlegmonous tonsillitis, etc., in which diphtheria does not play any rôle. Equal parts of *glycerin* and *guaiacol* for adults, two parts of *glycerin* and one of *guaiacol* for children. Paint affected parts four times in twenty-four hours, making the last application late at night and the first early in the morning. Fever rapidly diminishes and food can be taken without pain. (DARBOUET, *Jour. de Méd. et de Chir. Prat.*, January 10, 1895.)

Guaiacol Carbonate.—Used in one hundred and sixty cases of phthisis by author, 2 to 3 grammes (31 to 46 grains) daily in two doses, increasing gradually to 6 grammes ($1\frac{1}{2}$ drachms) when indicated. Preferable to *creasote* or *pure guaiacol* because it does not disturb digestion, is taken into the blood in small quantity only, and exerts a milder influence. Appetite and assimilation of food improved. Valueless in acute miliary tuberculosis. (HÖLSCHER, *Berliner klin. Woch.*, December 3, 1895.)

Hæmatemesis from Gastric Ulcer.—Enjoin absolute rest in bed, forbidding motion or speech. Apply an ice-bag over the epigastrium. Order iced drinks, ice to suck, and every two hours a cachet containing *sodium bicarbonate*, 0.50 gramme ($7\frac{3}{4}$ grains); *ratanhia-powder*, 0.10 gramme ($1\frac{3}{4}$ grains); *opium-powder*, 0.01 gramme ($\frac{1}{6}$ grain). Give an hypodermatic injection, every half-hour, of 1 cubic centimetre ($15\frac{1}{2}$ minims) of the following solution: *Ergotine*, 2 grammes (31 grains); *glycerin*, *cherry-laurel water*, each 5 grammes ($1\frac{1}{4}$ fluidrachms); as food, a glass of iced milk every two hours, and an injection of yelks of 2 eggs, 10 grammes ($2\frac{1}{2}$ drachms) of dry peptones, and 300 grammes ($9\frac{1}{2}$ fluidounces) of milk. Between the attacks have the patient observe a strict milk diet, taking a glass of fresh milk every two hours, with a teaspoonful of dry peptones if the pain is not too severe. Follow the milk with *bicarbonate of soda*, giving a little in water after each glass of milk. If pain is very severe, prescribe the following: *Hydrochlorate of morphine*, 0.05 gramme ($\frac{7}{8}$ grain); *hydrochlorate of cocaine*, 0.50 gramme ($7\frac{3}{4}$ grains); *cherry-laurel water*, 10 grammes ($2\frac{1}{2}$ fluidrachms); *julep*, 100 grammes ($3\frac{1}{4}$ fluidounces). A tablespoonful

Hæmatemesis from Gastric Ulcer (*continued*).
three times a day. Continue the treatment until pain has completely ceased, when food may be gradually resumed, preparations of milk, eggs, and meat-powders being first allowed, milk with Vichy water being the only drink. (MALBEC, *Tribune Médicale*, December 19, 1894.)

Hay Fever.—*Liq. pot. arsenitis, ext. nucis vomicæ fl., ext. cinchona fl.* (detannated), each 6 drachms (23 grammes); *alcoholis*, 3 ounces (93 grammes); *syrup. aurantii*, q. s. ad 16 ounces (500 grammes). One or two teaspoonfuls three times daily, with or after meals. To be commenced at least six weeks before time of annual recurrence of disease, and continued for three months or longer if necessary. Proper hygienic surroundings and diet, avoidance of physical and mental overstrain also important. (A. L. HALL, Fair Haven, N. Y., *Buffalo Medical and Surgical Journal*, January 1895.)

Ioteric Pruritus.—*Alcohol, sulphuric ether*, each 40 grammes (1¼ fluidounces); *ichthyol*, 10 grammes (2½ drachms). Rub thoroughly into the skin. Dissolves cholesterine crystals irritating the excretory canals of sudoriparous system, and prevents them from forming again by impregnating them with a resinous substance. (BOULLAND, *Jour. de Méd. et de Chir. Prat.*, January 10, 1895.)

Laryngitis Stridulus.—*Bromide of potassium* in large doses, continued for several days. In a child of 21 months, the dose was gradually increased by the author until it reached 1.50 grammes (23¼ grains). Important to continue treatment for five or six days, to prevent return of the attacks. (HUCHARD, *Jour. des Praticiens*, December 1, 1894.)

Mixed Chloroform Anæsthesia.—Administer *choloroform* by the classic method. As soon as the face becomes pale, inject subcutaneously, on the outer surface of the thigh, 4 cubic centimetres (1 fluidrachm) of a solution consisting of 1 part of good *cognac* and 2 parts of *distilled water*. Repeat injection three or four times until the pulse becomes good. Also indicated in cases of sudden syncope after hæmorrhage or shock. Can be administered before, during, and after chloroformization in cases of cachexia or debility. Devoid of danger and well tolerated. Tried by the author in three hundred cases of chloroform anæsthesia at the Hôpital de la Conception, Marseilles. (POUCEL, *Journal des Praticiens*, January 5, 1894.)

Pityriasis Versicolor.—*Cold cream*, 40 grammes (1¼ ounces); *unwashed precipitated sulphur*, 4 grammes (1 drachm); *iodide of sulphur*, 2 grammes (½ drachm); *red oxide of mercury*, 1 gramme (15½ grains). Rub in well three times daily, then dust with a powder made of *talc* and *starch*. (MONIN, *Mouvement Thér. et Méd.*, December 1, 1894.)

Psoriasis Palmaris.—*Rectified spirits of wine*, 5 drachms (20 grammes); *sulphuric ether*, 3 drachms (12 grammes); mix; add *gum mastic*, 25 grains (1.6 grammes); when dissolved, add *salicylic acid*, 1 drachm (4 grammes). An excellent varnish. Apply a cold-starch poultice for a

few hours, to allay any irritation caused by its use. To wash the hands use (instead of soap) very hot water with *quillaia-bark*, mixing the fluid extract with a small quantity of *coal-tar* (*liq. carbonis detergens*). (H. S. PURDON, Belfast Skin Hospital, *Dublin Journal of Medical Science*, January, 1895.)

Purulent Infection in the Lying-in Period.—Intra-uterine injections of *iodine;* if the temperature do not fall, curetting, or at first simple swabbing out of the uterus. As much nourishment as possible, with alcoholic drinks. *Quinine*, 1 gramme (15½ grains) in two doses, morning and evening, increasing to 1.50 grammes (23¼ grains), but not exceeding 2 grammes (31 grains) in twenty-four hours. Cold ablutions; wet cloths on the head, stomach, and thighs; wet packs, or cold baths. When temperature exceeds 38.5° C. (101.4° F.), no cold baths. (TARNIER, *Jour. de Méd. de Paris*, January 6, 1895.)

Salaktol.—New remedy for diphtheria, made of *hydrogen peroxide*, *sodic salicylate*, and *sodic lactate*. Applied with a pencil to affected portions of throat or, when this was not practicable, given as an inhalation. Also used as a gargle, and tablespoonful doses given after each local application, the latter being made every three hours, or every two hours in urgent cases. Acts as a rapid disinfectant, loosening and dissolving the false membrane. Antipyretics rarely necessary. Tried by the author in fifty-two cases without a failure. (WALLE, *Deut. Med. Zeit.*, November 15, 1894.)

Test for Albumin.—Mehn's test, as modified by Millard: *Acid. phenic. glac.*, 95 per cent., ½ ounce (16 grammes); *acid. acetic. puri*, 1¾ ounces (60 grammes); *liquor potassæ*, 5½ ounces (170 grammes). Reduce *glacial phenic acid* to 95-per-cent. solution at moment of compounding, or resultant fluid will be turbid. All ingredients must be chemically pure. To 5 cubic centimetres (1¼ fluidrachms) of urine in a test-tube add 0.5 cubic centimetre (7¾ minims) of the test slowly from a pipette, to underlie the urine. If albumin be present a white, milky ring will appear, varying in depth and density to a faint, milky cloud, and will give the quantitative and qualitative result. (P. J. MCCOURT, *Medical Record*, January 12, 1895.)

To Detect the Bacillus of Typhoid Fever.—Decolorize an ordinary bouillon with *animal black;* add *carbolic acid*, 1 per cent.; *milk-sugar*, 20 per cent.; and small quantity of *Congo red*. If the bouillon remain clear, neither the typhoid nor the coli bacillus is present. If the typhoid bacillus be present the milk-sugar does not ferment; the bouillon becomes cloudy, but remains red. If the coli bacillus be present the bouillon becomes cloudy; the lactose ferments, forming lactic acid, changing the bouillon from red to violet. (LYONNET, *Semaine Méd.*, November 3, 1894.)

Traumatic Neuritis.—Method of treating neuritis following a contused wound, incision of a phlegmon, amputation of a finger, etc., hysteria or general neuritis being excluded: Determine the extent of the hyperæsthetic

Traumatic Neuritis (*continued*).

area, the patient being either in the lying or sitting position; take the finger or affected part between the thumb and index finger, and press sucessively with all your strength on the hyperæsthetic zone, commencing at the most painful points, upon which exert most force, then upon the wound or cicatrice and near it. The first compression should last only a few seconds, and is generally sufficient to cause the disappearance of the pain. If it persist, let an assistant make a second compression. In some cases a second or third compression may be necessary at intervals of four or six days. Cover the compressed area for eight or ten days with cotton-wool. Hyperæsthesia and trophic troubles entirely disappear. Eight cases were thus treated by the author with success. (DELORME, Val-de-Grâce, *Gazette des Hôpitaux*, January 1, 1895.)

Traumaticine in Syphilis.—Use 25 grammes (6½ drachms) of *calomel* to 75 grammes (2½ ounces) of the *traumaticine;* with a camel's hair brush apply to the portions of the body covered with the eruption, painting a large part of the back the first day, the chest two days later, the thighs two days afterward, then the buttocks, returning again to the trunk. Three applications a week sufficient for an ordinary case of syphilis. Corresponds to treatment by pills, but does not interfere with the digestive functions. Less active than inunctions. The dermatoses disappear in three weeks. The traumaticine is so adherent that the patient may bathe regularly without interfering with the treatment. (JULLIEN, *Revue Inter. de Thér. et de Pharm.*, November, 1894.)

Monographs Received.

The editor acknowledges, with thanks, the receipt of the following monographs:—

Contribution to the History of Medicine in Southern California, by **Cephas L. Bard**, Ventura, Cal.——A Case of Chronic Peritonitis, with Intestinal and Abdominal Fistulæ: Enterorrhaphy; Recovery. By **Frederick Holme Wiggin**, New York.——Intra-ligamentous and Retroperitoneal Tumors of the Uterus and its Adnexa, by **William H. Wathen**, Louisville, Ky.——Deux Cas de Surdité Hystérique, par **A. Cartaz**, Paris.——Crises Gastriques du Tabes, Urologie et Chimisme Stomacal, par **H. Cathelineau**, Paris.——Cœliotomy for Bilateral Pyosalpinx, followed four days later by Appendicitis. A Case of Ovarian Fibrosarcoma. By **Frederick Holme Wiggin**, New York.——La Maladie des Trieurs de Laine, par **Samuel Lodge, fils**, Paris.——Essai de Chimie Biologique, appliqué à l'étude de l'action physiologique et thérapeutique des Eaux Minérales de la Bourboule, par **L. Heulz** et **H. Cathelineau**, Paris.——Tuberculosis in the Ano-Rectal Region, by **Thomas H. Manley**, New York.——De la Maladie de Basedow et en particulier de sa Pathogénie, par **Frederick Chamberlain**, Paris.——Contusion of the Abdomen, with rupture of the Thoracic Duct, by **Thomas H. Manley**, New York.——Des Frictions Mercurielles, par **H. Cathelineau**, Paris.——The Nature and Treatment of Leprosy, by **R. H. L. Bibb**, Saltillo, Mexico.——Sur l'Emploi des Fluorures dans les Industries, par **H. Cathelineau** et **A. Lebrasseur**, Paris.——Rest in Bed as a Resource in the Treatment of Chronic Non-Suppurative Catarrh of the Middle Ear, by **A. Britton Deynard**, New York.——Intestinal Anastomosis, with Report of a Case, by **F. H. Wiggin**, New York.——Glossite Folliculeuse Aigue Infectante, par **Vincenzio Garzia**, Naples.——Bulletins et Memoires de la Société Française d'Otologie, de Laryngologie, et de Rhinologie. Tome x. Paris, 1894.——Die Nachkommen Cortes' und Moctezumas, von **Friedrich Semeleder**, Mexico.——Trattato di Patologia Speciale Medica e Terapia, ad uso degli Studenti e dei Medici, pel **Temistocle Santopadre**, Ferrara.——The Relation of Static Disturbances of the Abdominal Viscera to Displacements of the Pelvic Organs, by **J. H. Kellogg**, Battle Creek, Mich.——Neuer experimenteller Beitrag zum Studium des Erythrasmas, von **A. Ducrey** und **A. Reale**, Neapel.——Proceedings of the Society for the Study of Inebriety, No. 42, London, 1894.——Report on Typhoid Fever in the District of Columbia, Submitted to the U. S. House of Representatives, June 14, 1894, Washington, D. C.

EDITORIAL STAFF

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CHARLES E. SAJOUS, M.D., EDITOR-IN-CHIEF,

28 RUE DE MADRID, PARIS, FRANCE.

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(End of Editorial Department of Journal for February, 1895.)

THE REAL VALUE OF THE MEDICINAL PEROXIDE OF HYDROGEN PREPARATIONS FOUND IN THE MARKET.

By H. Endemann, Ph.D., Chemist.

Formerly with the Health Department of New York City.

My attention having repeatedly been called to several reports and analyses made by different chemists and published by some medical journals, I concluded to examine all the brands of peroxide of hydrogen which I could find on the market, in order to ascertain the real value of each when intended to be used as an antiseptic remedy, both internally and externally.

The reports on the subject which have come to my knowledge are quite contradictory, and my object is to impart to the medical profession the results of my experiments, which have been made on fourteen fresh samples, purchased by me in duplicate, directly from the manufacturers or their selling agents.

These brands have been tested for the volume of available oxygen, the amount of residue, the degree of acidity, and the amount of soluble baryta salts contained therein, as per following table :—

Brands.	Volume of available oxygen determined by means of a solution containing 5.665 grammes of permanganate of potash per litre of distilled water.	Residue obtained from 100 c c of peroxide of hydrogen dried at 120° C.	Acidity expressed in cubic centimetres of normal volumetric soda solution for 100 c. c. of peroxide.	Baryta found in soluble baryta salts contained in 100 c. c. of peroxide.
No. 1. John Bene's Peroxide of Hydrogen Medicinal	10.50	0 1886	2.19	None.
No. 2. Hydrozone	27.35	0 2180	3.11	None.
No. 3 Larkin & Scheffer's Peroxide of Hydrogen Medicinal	9.65	0 1206	6.75	None.
No 4. Mallinckrodt's Peroxide of Hydrogen Medicinal	9.55	0.1408	1.43	None.
No. 5. Marchand's Peroxide of Hydrogen Medicinal	16 55	0.564	1.29	None.
No. 6. McKesson & Robbins's Peroxide of Hydrogen Medicinal	10.95	0.0540	0.44	None.
No. 7. Merck & Co.'s Peroxide of Hydrogen Medicinal	0.50	0.2418	4.57	None.
No. 8. Oakland Chemical Co.'s Peroxide of Hydrogen Medicinal	10.50	0 0385	0.34	0.0017
No. 9. Peuchot's Peroxide of Hydrogen Medicinal	10.60	0.4674	1 77	0.0018
No. 10. Powers & Weightman's Peroxide of Hydrogen Medicinal	8.40	0.0830	2.03	None.
No. 11. Pyrozone, 3 per cent.	11 20	0.0534	0.76	None.
No. 12. Rosengarten & Sons' Peroxide of Hydrogen Medicinal	3.10	0.1002	0.25	None.
No. 13. Smith, Kline, & French Co.'s Peroxide of Hydrogen Medicinal	6.15	0 0880	2 6	None
No. 14. E. R. Squibb's Peroxide of Hydrogen Medicinal	12.40	1.004	12.04	None.

By referring to this table it is easily understood that sample No. 2, "Hydrozone," is far superior to any other brand which has ever been made, not only on account of its containing a much larger amount of available oxygen, but also owing to he presence of a small quantity of several essential oils, the respective nature of which could not be determined, very likely because they have been submitted to the oxidizing action of peroxide of hydrogen before being used to make "Hydrozone."

I attribute to this small quantity of essential oils the great superiority of hydrozone over any other brands of H_2O_2 as a healing agent.

When hydrozone is diluted with distilled water, in the proportion of half and half, the resulting mixture contains about 13.5 volumes of available oxygen, and its

(Continued on page 18.)

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Selections from Society Proceedings.

FRANCE.

SOCIÉTÉ DE CHIRURGIE.

Dangers of Massage of the Uterus.—M. POZZI presented the specimens from a case illustrating the injurious effects of massage in suppurative lesions of the appendages. A patient suffering from metritis and double salpingo-ovaritis, after an attack of pelvic peritonitis diagnosed as hæmatocele, was treated by massage, the operator being a skilled one. The treatment was badly borne and caused no improvement. M. Pozzi afterward performed laparotomy and extirpated both tubes, which presented the external appearances of pyosalpinx. Outside of the left tube there was a small purulent area. On opening the tubes the left one was found to contain blood and the right a rose-colored pus. Under the influence of the pressure exercised during the massage, rupture of the vessels and hæmorrhage in the tubes had evidently occurred. The same pressure might also have driven pus out of the tube, thus explaining the purulent area found on the wall of the pelvis at the outer extremity of the tube. M. Pozzi believed that massage should be reserved for chronic cases in which there was no suppuration.

M. BOUILLY reported several cases illustrating the bad effects of massage. A woman with a neoplasm in the posterior *cul-de-sac* was submitted to massage, when suppuration of the tumor took place, causing the death of the patient. Another case of simple retroversion suffered the most painful symptoms after massage, and a third was confined to bed from its effects, though she had only a slight ovarian affection. The indications and contra-indications of the treatment should be clearly defined.

M. LUCAS-CHAMPIONNIÈRE had also observed similar ill effects and had been recently obliged to perform laparotomy in one such case and hysterectomy in another.

M. RICHELOT had performed hysterectomy on a patient who had undergone treatment by massage with only temporary relief.

M. ROUTIER stated that he had made use of massage in his practice for the past eight months with good results, but that he employed it only in cases in which no lesion existed.

M. MONOD regarded the method as an excellent one when suppuration was not present, and in this opinion the members generally concurred, stating that they wished only to call attention to the dangers of its abuse and the necessity of intrusting the cases to incompetent persons.

SOCIÉTÉ MÉDICALE DES HÔPITAUX.

Abscess of the Liver Mistaken for Purulent Pleurisy.—M. HANOT described a case of this kind in a woman, 45 years of age, who had been sent to hospital for purulent pleurisy. Three successive incisions were made in the eighth right intercostal space, the first two punctures being followed by the escape of about 300 grammes (9½ fluidounces) of fetid pus. Relief not being experienced, the ninth rib was resected for about three centimetres, the pus-sac incised, and a couple of drains placed in the wound. The cavity was washed out, but the temperature remained high and the patient finally died. A post-mortem examination showed the right lung pushed upward and in a condition of atelectasis, from the pressure of an encysted serous effusion containing some 700 grammes (22½ fluidounces). The right lobe of the liver was like an immense sponge filled with pus, each little pocket being separated from its neighbor by but slightly-altered hepatic tissue. An abscess the size of a nut occupied the left lobe of the liver. The pus was examined bacteriologically and a few chains of streptococci were found among the white cells. Inoculation experiments showed these microbes to be absolutely sterile. M. Hanot expressed the opinion that in a similar case, if examination of the pus showed it to be sterile, a diagnosis of abscess of the liver rather than of purulent pleurisy should be made.

Electricity in the Intestinal Paresis of Typhoid Fever.—MM. FERNET and MARTIN employed this method in a case of a woman, aged 35 years, convalescent from severe typhoid fever complicated with broncho-pneumonia. The only symptom left was a tympanitis due to paresis of the intestines. The continued current was used, one pole being placed on the lumbar region and the other moved about over the large intestine. After the first application a spontaneous evacuation of fæces and gas occurred, and complete cure was effected in six more *séances*, a current of 6 milliampères being employed.

Infantile Myxœdema.—M. LE BRETON reported a new success with the thyroid treatment in this disease. His patient was a boy, aged 13 years, in whom myxœdema had appeared at the age of 3. The symptoms were pronounced,—arrest of development, deformity of the bones of the head, imperfect intelligence, slowness of movements, and absence of the thyroid body. He was given one fried lobe of thyroid gland daily, and in fifteen

days marked improvement was visible. At the time of report, nine months after the treatment was begun, he could run up stairs, his mental faculties were brighter, and his physical condition much better. The case is one of recovery, in the author's opinion; but a recovery depending upon the continuance of the treatment, for when this is suspended intellectual torpor appears.

SOCIÉTÉ OBSTETRICALE ET GYNÉCOLOGIQUE.

Premature Births.—M. VILLEMIN reported the case of a child, 2 years old, who was born in the sixth month of pregnancy. He could vouch for the truth of the fact that the child had not had six months of intra-uterine life, the last menstrual period of the mother (a multipara), the date of the first fœtal movements, the weight of the child (950 grammes—30½ ounces), and its appearance, all bearing out the statement.

M. BUDIN had had the infant under observation from the beginning, and stated that the dates were exact. He did not think the child could be raised. He had examined infants of six or seven months, that had cried and had lived a few days, and had found the alveolar cavities filled with epithelial cells, the lung sinking to the bottom when placed in a vessel filled with water. The case is interesting from a medico-legal stand-point, as according to law, the child not being six months, it would not be necessary to declare its birth.

M. CHARPENTIER had a case of premature birth in his practice, the child certainly not being more than 6½ months, and weighing 1040 grammes (33⅓ ounces). He was so sure that it would not live that he put it in a basin while he gave his attention to the mother. Having attended to her needs and the child being still living, he wrapped it in cotton, and was surprised, next day, to find it alive. He then had it put in a small, well-heated room and fed with a spoon on woman's milk; on the twelfth day it could take the breast, and it has since thrived and grown.

GERMANY.

VEREIN FUR INNERE MEDIZIN, BERLIN.

Lactic Acid as a Sign of Cancer of the Stomach.—HERR G. KLEMPERER, in discussing the chemical diagnosis of cancer of the stomach, stated that he had recently examined fifteen patients in Leyden's clinic, under treatment for this disease, and had found lactic acid present in the gastric juice in every instance. However, he could not admit without reserve that it was a pathognomonic sign, since he had not found it in three other cases of gastric cancer, one of which came to autopsy. It seemed to him that a lessened contractility of the stomach might account for its appearance, as it was always present when there was a stagnation of the stomach-contents, as in cancer or ulcer, with stricture of the pylorus. He had also met with it in the later stages of heart disease and uræmia, and even in one case of simple gastric catarrh. However, it is a fairly-reliable sign of cancer,

which should always be thought of when its presence is ascertained. In closing his remarks, Herr Klemperer showed some post-mortem specimens from a man, 57 years of age, who had suffered from cachexia so characteristic that a diagnosis of gastric cancer was made at first sight. Palpation showed the presence of irregular tumors of the liver, and cancer of that organ was diagnosed, but, on account of the anorexia from which the patient suffered, cancer of the stomach was also admitted. No lactic acid was found in the gastric juice, and post-mortem examination showed the stomach to be normal, while the liver was the seat of a large carcinoma.

The Anatomical Lesions of Gastro-enteritis and Cholera Infantum.—Prof. Heubner, recently appointed to the Children's Clinic at Berlin, in a communication on this subject, stated that he had examined the intestines of nursing-infants dying from other diseases than those of the alimentary tract, and had observed a rapid alteration in the intestinal epithelium even after a lapse of a few hours. In cases in which the post-mortem examination had been made from twelve to twenty-four hours after death, the shape of the cells had entirely disappeared and a sort of partly-desquamated membrane had formed. If the intestine had been contracted at the moment of death, the glands were found lying close together, and the vessels were devoid of blood, causing a certain degree of anæmia of the mucous membrane, which occurred after death. If the intestine, on the contrary, had been relaxed, the glands were widely separated and the vessels engorged, causing hyperæmia, also cadaveric. These conditions of epithelial desquamation—hyperæmia or anæmia—Professor Heubner regarded as normal, no pathological changes of the intestine being found.

In three cases of subacute gastro-enteritis with dyspepsia, examined after death, he found a degeneration of the mucous membrane of the gastric glands, the cells, however, being normal. The epithelium of the large and small intestines was intact, but in the former was considerably degenerated. In cases of cholera infantum the changes were more extensive. The stomach was filled with lumps of mucus; the epithelium of the large intestine, jejunum, and ileum was in a necrosed condition, causing a loss of the power of absorption and secretion; the villi were united, forming a uniform mass. Professor Heubner did not determine the nature of the micrococci present, although he found no specific bacteria. The lesions did not, in his opinion, account for death, which he was inclined to attribute to an auto-intoxication of intestinal origin, the disease, like other infections, proving fatal before any appreciable anatomical lesions resulted.

Berliner medicinische Gesellschaft.

New Diaphragmatic Phenomenon.—Herr Litten described this phenomenon, which he had observed and studied for some time, and which he believed he was the first to report. It consists of a sort of undulating line extending from the vertebral column to the seventh rib, and synchronous with the movements of the diaphragm. In a normal individual this line of movement of the diaphragm can be seen on the thoracic walls, the intensity

of the inspiration and the limits of the diaphragm during inspiration and expiration being thus shown. Percussion is not necessary, therefore; since the upper point marks the upper margin of the liver in a state of rest and the lower in deep inspiration. The phenomenon is of interest to the physiologist, aiding him in studying the movements of the diaphragm; and of greater interest to the pathologist, in determining whether abnormal conditions exist. In emphysema the line is lower and more limited. The normal movement of the diaphragm is seven centimetres, and in pleurisy with effusion it is much less. If the diaphragm is seen above the zone of dullness, the case is one of subphrenic abscess; if below, it is one of pleuritic exudation. He presented a case of echinococcus of the liver in which the diagnosis could easily be made by means of the phenomenon.

GREAT BRITAIN AND COLONIES.

MEDICO-CHIRURGICAL SOCIETY OF EDINBURGH.

Successful Case of Cardicentesis.—DR. ALLEN THOMSON SLOAN presented a patient whom he believed to be the only person who had undergone cardicentesis and had continued to live. This patient was a girl of 19 years, fairly healthy, who, during convalescence from a severe attack of erysipelas, and before she had left her bed, was suddenly affected with rheumatic fever. There was a marked family history of rheumatism and an individual susceptibility to the disease on the part of the patient, this being her fourth attack of rheumatic fever. In spite of all efforts her condition grew worse and worse, no doubt being aggravated by the knowledge that her dying father was being removed from the country, in the vain hope of prolonging his life, without a parting interview with her. The livid, anxious countenance, the pallor of the lips, the working of the alæ nasi, the dilatation of the veins of the neck, and increased general restlessness, all indicated rapid effusion into the pericardium, which physical examination too truly revealed. The area of cardiac dullness was greatly increased, extending fully half an inch to the right of the sternum, up to the second interspace above, but below and to the left was indistinguishable from a dullness which extended over the whole of the left lung, doubtless due to compression from the bulging pericardium, and probably also to some actual pleuritic effusion, as all breath-sounds were inaudible over the whole of the left base and up to the middle of the scapula. Friction was still to be heard, but the actual heart-sounds were distant, feeble, and obscure. So grave did the state of the patient become that, in a consultation with Dr. Bramwell, the question of tapping the pericardium was not even mentioned.

The following day, Dr. Sloan was hurriedly summoned by a messenger who said that the patient was just dead. He found that the pulse was uncountable and hardly to be felt, the livid pallor of the face, profuse cold perspiration, and changing, startled expression indicating approaching death. He at once injected 30 minims (2 cubic centimetres) of ether into the arm, and, sudden dilatation of the pupils and rapid receding of the pulse

showing the further need of stimulation, he injected 30 minims (2 cubic centimetres) more into the left breast. Immediately afterward the heart and respiration stopped, and, in the moment of excitement, Dr. Sloan seized the aspirator (which he had prepared earlier in the day and set up in an adjoining room) and plunged the needle into the fourth interspace, about half an inch to the left of the sternum and a little below the left nipple. From 8 to 10 ounces (250 to 310 cubic centimetres) of pure blood flowed rapidly into the bottle of the aspirator and then suddenly stopped. To his dismay he found that he had penetrated a cavity of the heart. As he was slowly withdrawing the cannula (a space of about half a minute), the heart made first a feeble, irregular movement, then gave a sudden strenuous jump, and finally, like a pendulum regaining its swing, it started to beat again. For an hour the scene was pitiful. Occasionally there was a heart-rending shriek; quantities of frothy mucus were half coughed, half vomited, and had to be swept out of the mouth with a towel; the blood went ebbing and flowing from the cheeks, which were first ashy gray, then purplish in hue; the pupils were dilated to their fullest extent; the running, following pulse was quite uncountable, and the patient had every appearance of one dying asphyxiated. Another drachm (4 grammes) of ether was injected, with the result that the patient became maniacal, and, at Dr. Bramwell's suggestion, first $\frac{1}{6}$ and then another $\frac{1}{6}$ grain (0.01 gramme) of morphia was administered hypodermatically to keep her quiet. Drs. Bramwell and Smith thought it quite impossible that the patient could live through the night. In another hour, however, her aspect had vastly improved, the lividity of the countenance and pallor of the lips had disappeared, the breathing was easier, and the mania was succeeded by the most delightful feeling of intoxication.

During the night the patient was inclined to wander, but in the morning consciousness had completely returned and she was able to take half a cup of tea and a biscuit. The pulse varied from 118 to 122 per minute, and was still very feeble and irregular, with a long pause at every fourth beat. The most absolute rest was enjoined; liquid nourishment was given in small quantities frequently, and stimulants only in 1-drachm (4 grammes) doses, and with caution, for fear of overexciting the already too tremulous heart's action. In the afternoon the temperature rose to 101.4° F. (38.5° C.), but this was accounted for by the exhaustion and the general feeling of soreness, due to lying continuously in the same position. As there was still a tendency to mental excitement, and no further sleep had been obtained, at 12.30 A.M. 15 grains (1 gramme) of bromide of potassium were given, after which she slept till 2 A.M. At 4.20 there was great restlessness, and another 15 grains (1 gramme) were given, with the result that repeated short sleeps were obtained between the periods of taking food. Two days after the operation the temperature fell suddenly to normal and the pulse from 104 to 40, which occasioned great anxiety; and this happened from time to time, till the pericardial effusion cleared away, about eight days afterward, while the slightest movement on the part of the patient caused immediate paling of the lips and face. The daily progress of the case was hourly observed and noted by

the two nurses, to whose superb after-attention the patient owes her life. After the fifth day there was no rise in the temperature above 99° F. (37.2° C.) until July 2d, and it was then due to slight gastric disturbance, the consequence of overfeeding; the pulse first became regular, then gradually slower, till on the 22d of June it reached the normal rate of 76; and the respirations, which had varied from 22 to 30, correspondingly declined to 18 per minute. During the first twenty-four hours no urine was passed, and for seven days afterward only 12 to 14 ounces (375 to 435 cubic centimetres) daily, thick with urates; but the patient continued at times to perspire very freely. Solid food in the form of white fish was first given six days after the tapping, and the cardiac tonic of arsenic, strophanthus, strychnine, and iron, formerly given, was resumed. Bananas and oranges and strong soups flavored with vegetable-juices were ordered, with a view to combating the profound anæmia which had ensued. Stimulants were only administered when specially called for, and the bowels were relieved by glycerin enemata. The only complaint the patient had was about the soreness of her bones, owing to her great emaciation; but an attempt to put her on a water-bed caused such alarming faintness that it had to be abandoned.

The gradual disappearance of the pericardial effusion was further hastened by the daily external application of iodine. In December, six months later, the patient was in excellent health, had had no return of the rheumatism, and the cardiac murmur had entirely disappeared.

Dr. Sloan, having performed cardiac tapping successfully by accident, expressed the opinion that cardicentesis, followed by artificial respiration, is the proper treatment in all cases of asphyxia where the heart's action has stopped. The operation was originally proposed and performed by Dr. Westbrook, of Brooklyn (*Medical Record*, December 23, 1882), as a substitute for venesection, in the belief that the dyspnœa, due to a dilated heart or the pulmonary engorgement of an acute pneumonia, would be more readily relieved by drawing a few drachms of blood direct from the heart than by taking a similar number of ounces from a vein. He advised that the right auricle be tapped in the third costal interspace, close to the right edge of the sternum. Dr. J. B. Roberts, of Philadelphia, the chief authority on tapping of the pericardium, prefers (*Transactions of the College of Physicians*, Philadelphia, 1883, vol. vi, p. 217) to perforate the ventricle of the right heart through the fourth interspace, about one and a half or two inches to the left of the median line of the sternum.

Dr. Bramwell said that Dr. Sloan's case was a severe one of rheumatic fever with cardiac complications. When he saw the bottle full of blood, the patient unconscious, with dilated pupils, bringing up frothy mucus, he certainly thought she had only a few minutes to live. No doubt Dr. Sloan had saved her life by tapping the heart. Whether the heart ought to be tapped was a difficult question to answer. He could quite conceive that in desperate cases the expedient might be employed. For his own part, he would hesitate to employ it except in extreme conditions. He had only once tapped the heart, and the result was not so fortunate. The patient was in Edinburgh Infirmary with ulcerative endocarditis. The heart was much

dilated, but dullness seemed to be too extensive to be accounted for by simple dilatation. He was under the belief that there was some pericardial effusion as well. He determined to tap, and introduced the ordinary diagnostic syringe in use in the ward. Instead of entering a dilated pericardium he found he had punctured the heart. He withdrew the syringe full of blood and then withdrew the needle. The patient died in about half an hour. Dr. Bruce found the pericardium distended with black blood and a small wound in the anterior wall of the right ventricle. The bleeding into the pericardium was due to the extremely relaxed and diseased condition of the cardiac muscle. There was extensive ulcerative endocarditis. The case certainly showed that the operation was not without danger, and had made him extremely careful. He would certainly use the finest needle the blood would go through.

Dr. Joseph Bell stated that he had, on one occasion, been sent for to make a post-mortem on a young man who had been accidentally stabbed with a small knife. He opened the body carefully, and found the pericardium distended with blood and a small wound in the right ventricle. The youth had run for some distance before he died. If the surgeon had simply dilated the wound and cleared out the clot, he might, by draining under antiseptic precautions, have saved the young man's life.

Dr. Taylor was struck by the discrepancy in the views expressed by Dr. Bell and Dr. Bramwell. The lesson Dr. Bell had learned from the case was to open the pericardium freely, so as to avoid the risk of a clot forming within it by blood oozing from the puncture in the wall of the heart; whilst Dr. Bramwell said that in dealing with a similar case he would only use a fine needle. Now, this would appear to be the very way to get blood to escape into the pericardium and so form a clot within it which would effectually stop the heart's action. He was of opinion that the success of Dr. Sloan's case was probably due to the aspirator withdrawing 10 ounces (335 grammes) of blood from the heart. The patient would be practically pulseless and, the heart being thus at rest, the internal wound would have an opportunity of closing, the pressure within being so much reduced that the contraction of the distended walls of the heart, when so relieved of pressure, would be sufficient practically to close the opening as soon as the needle of the aspirator was withdrawn.

Dr. Affleck regarded the case as eminently worthy of being put on record. It illustrated the difficulty of determining whether one had to do with a dilated heart or pericardial effusion. Pure blood was withdrawn; so that in this case there was probably no fluid in the pericardium. Heart-puncture would not be so suitable for asphyxia in which it was the respiration and not the heart that was at fault.

Dr. Russell recalled a discussion that took place in the society ten years ago on tapping the pericardium, and to a case in which he made a like mistake, and which he supposed practically every physician had made. He aspirated under the belief that it was a distended pericardium, with the result that he punctured the ventricle. The mark of the needle was distinctly visible on post-mortem examination. Dr. Sloan's communication

might, to a certain extent, stimulate interference, but even two such cases as Dr. Bramwell's and Dr. Bell's would make the physician hesitate. When the heart was in a condition to justify such procedure there was almost always a fibrinous clot extending into the pulmonary artery, in which case tapping the right ventricle would do no good. Dr. Sloan's case, however, did hold out encouragement that in certain special cases the physician might adopt this procedure; yet the instances in which it would be calmly and deliberately recommended must remain rare and exceptional.

Dr. Stockman agreed with Dr. Taylor as to the aspiration relieving the condition. The right ventricle, when full, normally contained only about 4 ounces (125 grammes). In the present case 10 ounces (335 grammes) were withdrawn. Puncture disabled the heart rather than stimulated it. Experiments on animals had shown that it produced an arhythmical condition which tended to stop the heart. The practice had been the cause of death in cases in America.

Dr. Clouston recalled the case of a patient in Morningside Asylum who transfixed the apex of her heart with a long, steel pin, pushing it in almost to its head, with the effect of arresting the rhythmical action and producing apparent death. Dr. Joseph Brown, discovering the cause, withdrew the pin, and she was none the worse an hour afterward.

Dr. Sloan, in reply, said that whether puncture of the heart would cause bleeding into pericardium would depend on whether or not a cardiac vein were injured in the process. The heart-muscle might close the opening. He was still of opinion that his case was one of pericardial effusion, the history being against so rapid and marked a dilatation, and the dullness not disappearing immediately after the operation,—in fact, not till eight days afterward. He thought the ventricular muscle completely contracted, and, on withdrawing the cannula, he kept it close against the heart-wall. His case was not the only one that lived after the operation. Some other bad cases lived for five weeks, and even longer. That the operation was not in itself fatal had been amply proved.—*Edinburgh Medical Journal*, February, 1895.

Toronto Medical Society.

Laminectomy for Fracture-Dislocation in the Cervical Region.—Dr. Frederick Winnett presented the report of a case of this kind in a man, of 29 years, who had fractured the cervical vertebræ while bathing. Running ten or fifteen yards, he dived from the pier about three feet above the water, which was not more than four feet deep. His head was seen to strike the sand, doubling under him, and his body float to the surface. When rescued he said he experienced a terrible shock through his body and that he had hurt his neck.

His condition was as follows: Mind perfectly clear. Sensation normal as low down in front as nipples and shoulders. Tactile sensation present, although indistinct, over the remainder of the surface, with the exception of forearms and hands. Contact of clothes hot and painful. Sense of pain absent. Retention of urine and unconscious defecation. Pupils con-

tracted. Some irregularity of the spines of fourth and fifth cervical and tenderness. All the muscles below the neck paralyzed, with the exception of the diaphragm.

On the following day Dr. Winnett assisted Dr. G. A. Peters to perform laminectomy. The patient was turned well on his right side and, in order to not embarrass the movements of the diaphragm, pillows were placed beneath chest and hips. His head was supported with sand-bags. The neck having been shaved and washed with a solution of carbolic acid, an incision was made from above down over the spines for about three or four inches, with its centre over the fourth or fifth spine. The spines and laminæ were quickly cleaned. The supraspinous ligament between the fourth and fifth vertebræ was found ruptured, spine of fourth bent to the left, and lamina of fourth on left side fractured. The edges of the wound were drawn apart with retractors, while the lamina of the fourth on right side was partly divided with Hey's saw and the division completed with the bone-forceps. The soft structures were divided, and with necrosis-forceps the spine and laminæ were drawn forcibly away. This exposed the cord surrounded by the membranes, which appeared healthy. As the membranes were tense, the lamina of fifth was similarly divided and removed. Pulsation was now noticed. A small spiculum of bone was removed from the membranes in the region of the fractured lamina, causing some blood to escape in a constant stream and cerebro-spinal fluid in a jetting manner, but this soon ceased. Hæmorrhage gave no particular trouble, and ligatures were not required. Deep sutures of silk-worm gut were inserted, and a superficial continuous suture of horse-hair. It was dusted with iodoform, and iodoform and double cyanide gauze applied, and a pad of absorbent cotton. The head was supported on a small pillow and sand-bags placed on either side. The operation occupied three quarters of an hour.

Ten weeks after operation the patient had sufficiently recovered to be removed to England, and nineteen weeks after the bladder was said to be normal and the left hand could be moved freely; but the right hand was not improved.

In connection with the diagnosis, Dr. Winnett pointed out the difficulty of localizing a lesion in the cervical region from an ordinary anatomical knowledge of the origin of the nerves. Speaking generally, we have the following: The musculo-cutaneous supplies the flexors of the elbow, but, as it receives fibres from the fourth, fifth, sixth, and seventh cervicals, its paralysis would leave the location of the lesion indefinite. In practice, however, the fifth nerve is found to preside over this action.

The musculo-spiral supplies the muscles on the back of the arm and forearm, and therefore extends the elbow and wrist. It, however, is made up of fibres from all the nerves from fourth cervical to first dorsal, and, consequently, helps a diagnosis very little. The sixth nerve extends the elbow and the seventh the wrist. The median supplies most of the flexors of the wrist, but, receiving fibres from all the plexus, it leaves a diagnosis uncertain. Here the eighth cervical is found to govern the action. The first dorsal supplies the intrinsic muscles of the hand.

Since the origin of these nerves is opposite the bodies of the vertebræ above, we have: Centre for flexing elbow, opposite body of fourth cervical; centre for extending elbow, opposite body of fifth cervical; centre for extending wrist, opposite body of sixth cervical; centre for flexing wrist, opposite body of seventh cervical; centre for hand, between seventh and first dorsal.—*Canadian Practitioner*, January, 1895.

THE INDIAN MEDICAL CONGRESS, CALCUTTA.

A Case of Lymphadenoma (Hodgkin's Disease) in a Native of India.—DR. J. CHAYTOR WHITE stated that the comparative rarity of this disease in the native of India was his excuse for bringing a case before the Congress, it being the first he had seen in that country. The patient, a man aged 36 years, was admitted into the Mozuffarnagar Dispensary on July 19, 1894, suffering from a series of multiple enlargements of all the superficial lymphatic glands of the body. He first remarked a swelling in his armpits a year ago, and in the following October the inguinal glands on both sides became affected. About three weeks ago he noticed swellings under the jaw and around the neck, when deglutition became difficult and his health bad. He had not suffered from syphilis. On examination it was evident that every palpable group of lymphatic glands was affected. The cervical chains were all enlarged, but had not become aggregated. The submaxillary, sublingual, and parotid glands of both sides were greatly enlarged and conglomerate. The adenoid tissue of the pharynx and fauces was involved, and the tonsils when palpated felt like almonds. The voice was hoarse and there was difficulty in deglutition, but the recurrent laryngeal was not paralyzed by pressure. The thyroid was much enlarged and the mediastinal glands were also manifestly involved. The mesenteric glands were easily felt on palpation, and from the enlarged retroperitoneal and lumbar glands of the left side there was a copious discharge of lymph, which found exit at the bottom of the abdomen above Poupart's ligament. There was no evidence of change in the thymus, nor was there any caseation or suppuration in any one of the enlarged glands. The spleen was considerably increased in size, smooth on the surface, and could be felt well below the ribs. The urine was normal. The blood was found to be distinctly deficient in red cells, which were only about 53 per cent. of the normal. Leukæmia was marked, there being an excess of white cells in the proportion of about 1 white to 75 red. The red cells were also poor in hæmoglobin, it being estimated at about 45 per cent. of the normal. On staining a specimen after Ehrlich's method with eosin and logwood, the eosinophile corpuscle was not found to be present. The temperature throughout the case under notice was of the curiously-characteristic hectic type. It never exceeded 102° F. (38.9° C.), and never quite touched the normal curve. No febrifuges were administered for its control. Dr. White tried thyroid-gland tabloids, but with absolutely-negative results.

RUSSIA.

PEDIATRIC SOCIETY OF ST. PETERSBURG.

Acute Nephritis in the Pneumonia of Children.—DR. POPOFF reported four cases recently under his care in which acute nephritis occurred in the course of pneumonia. The first patient, a girl of 12 years, had previously had pneumonia at the age of 4, but there had then been no trace of albumin in the urine. She was brought to the hospital suffering from fever, cough, and a painful point on the side. Her illness had begun eight days previously with vomiting, delirium and fever, and all the physical signs of pneumonia, which ended in crisis on the ninth or tenth day, with profuse perspiration. The urine was examined upon the day following her entrance to the hospital, and found to be scanty, cloudy, and full of albumin. Microscopical examination showed hyaline and hæmatin casts and leucocytes. These disappeared in a few days, but the urine continued to show a heavy precipitate of albumin. There was no œdema nor symptoms of uræmia. The general condition of the appetite remained excellent. Treatment with methylene-blue was without effect.

The second patient was a boy 5 years of age, without any previous history of disease. He was brought to the hospital for fever, dyspnœa, and generalized œdema, the latter symptom having appeared on the second day of the disease. All the physical signs of pneumonia, with albumin in the urine, were present. At the end of fifteen days the child left the hospital completely cured. The third case, a girl of 6 years, with pneumonia, passed urine containing blood-cells and hæmatin-casts and 1 per cent. of albumin. She died ten hours after her entrance into the hospital, and the post-mortem examination revealed the presence of pleuro-pneumonia, acute epithelial nephritis, and tumefaction of the spleen. The fourth case was that of a boy 12 years old, with pneumonia and urine rich in albumin. Autopsy showed adhesive pleurisy, double pneumonia, hypertrophy of the spleen, and parenchymatous degeneration of the liver and kidneys.

From these four cases Dr. Popoff concludes that nephritis generally appears on the fourth or fifth day of the pneumonia, the most common symptom being bloody and scanty urine. Anuria or uræmia may supervene, but the casts and hæmatins generally disappear rapidly. The duration of the neperitis may vary from eight to seventy days, though the average duration is from fifteen to thirty days.—*La Médecine Moderne*, February 6, 1895.

UNITED STATES.

PHILADELPHIA NEUROLOGICAL SOCIETY.

The Naming Centre, with Report of a Case Indicating its Location in the Temporal Lobe.—DRS. C. K. MILLS and J. W. MCCONNELL presented a paper on this subject. The setting apart of a special area with the designation *naming centre* is in accordance with the views of Broadbent, Küssmaul, and

Charcot. According to Broadbent, the formation of an idea of any external object is the combination of the evidence respecting it received through all the senses. For the employment of this idea in intellectual operations it must be associated with and symbolized by name. The structural arrangement connected with this process he supposes to consist in the convergence from all the receptive centres of tracts which go to a convolutional area on the sensory side of the nervous system, which may be called the *naming centre.* Its correlative motor centre is the propositionizing centre, in which names or nouns are set in frame-work for outward expression, and in which a proposition is realized in consciousness or mentally rehearsed. The destruction of this centre would cause loss of memory of names or nouns. As a provisional guess, Broadbent placed this centre in an unnamed lobule situated on the under surface of the temporal lobe, near its junction with the occipital lobe, where he believed fibres from all the perceptive centres converge to and end in the cortex of this region. A careful study of the entire subject of speech-disturbances, including an analysis of cases already reported, will be convincing as to the necessity of a higher area for thought and speech, intermediate between the sensory or receptive centres and the motor or emissive. Other names which have been applied to this centre or area are *idea centre* and *concept centre.* Some authorities, as Ross and Bastian, do not consider that it is necessary to have a particular region of the brain in which concepts are elaborated and symbolized by name; but even these authors acknowledge a special development of the cortex for concepts and names, though they would not restrict it to an isolated area.

The following case seems to be convincing as to the existence and localization of this naming or idea centre, not only supporting the separate localization of such a region, but also confirming Broadbent's speculation as to the position of this centre in the temporal lobe.

A white woman, married, aged about 45, complained for the first time five years before her death of numbness of the back of the neck and vertigo, and had an attack of excessive vomiting, lasting two days. Nothing could be learned of anything occurring again until three years later, when it was noticed that she did things differently from her usual custom. Dressmaking, at which she had been successful, was poorly done; she hung upside down a certificate of membership in a society to which she belonged without realizing her error. Her appearance also changed from that of a woman in her prime to one fast advancing in years. When she arose in the morning of December 3, 1893, she acted very strangely, was very nervous, imagined that she saw a light, could not read, and remarked that she "felt like killing her daughter." In the evening she was seized with convulsions, frothed at the mouth, and was unconscious. The next day she was very forgetful, but without apparent speech-trouble. She was confined to bed for two weeks, during which time she aged very rapidly and commenced to complain of severe headache and of numbness in the neck. Soon after this verbal amnesia became very evident.

The patient was first seen in consultation with Dr. Bowers, July 16, 1894. In April she had had a spell of vertigo on rising in the morning and

toward noon a second similar attack, and from this time on it had become almost impossible for her to name objects. Until the 1st of August she was seen five or six times, and careful examinations during this period showed neither anæsthesia nor paralysis. Ophthalmological examinations showed no optic neuritis, but an irregular left lateral homonymous hemianopsia. She was word-blind in large part, but not letter-blind, and could name single letters slowly. She could not name objects either from sight or touch. If a pencil, pen, scissors, or purse were held before her, or if she were allowed to touch them, she could not give their names, although she evidently understood what they were. On one occasion she spoke of the scissors as "what I sew with," and the purse as "what I buy with." At times she became much worried and emotional because of this inability to name objects. When such objects were named to her she would promptly and with evidence of satisfaction indicate that the names were correct; and she could also, as a rule, repeat the names when spoken before her, but not always quickly, and occasionally she had considerable difficulty in repeating them. When asked her first name she said "Margaret" with facility, but she had great difficulty in mentioning her last name unless it was repeated to her, although she sometimes succeeded without this prompting. She used "yes" and "no" properly, and in many ways indicated that she knew what the objects were and their uses, but could not give their names. She talked spontaneously, but not freely, rarely using concrete nouns, and sometimes misplacing words.

On August 1st she became unable to perform shoulder and elbow movements and leg and thigh movements on the right side, but retained power in the hand and fingers, foot and toes. Gradually the paralysis of the right limbs became complete, but without loss of sensation. The skin on the paralyzed side assumed a pinkish hue and its temperature was increased. The pain in the head disappeared when the paralysis became complete, but retured to some extent a week before her death. Three weeks before her death she regained some power in the toes and fingers. During the last few weeks of her life "yes" and "no" were the only expressions used by her. She became somnolent and, later, stuporous; she developed bed-sores and lost control over both the vesical and rectal sphincters. Death occurred September 10, 1894.

An autopsy was made forty-eight hours after death. In the course of the removal of the brain, a small, nodulated, half-disintegrated mass, about the size of a hickory-nut, was pulled out of the brain-surface at a position corresponding to the posterior fourth of the third temporal convolution. The surface of the third temporal in its posterior half, to a much less extent the second temporal in the same general region, and the fourth temporal presented a granular, slightly-disintegrated appearance. On cutting into the temporal lobe a hard tumor, yellowish-brown in color, was revealed, its hardest and apparently oldest part being at about the middle of the third temporal (medi-temporal) convolution, and passing slightly into the second temporal. The mass extended cephalad and caudad a short distance almost entirely in the white matter of the third temporal gyri, and a soft, nodulated,

disintegrated, more or less hæmorrhagic condition extended still farther, reaching caudad as far as the white matter of the middle of the occipital lobe, and cephalad to the junction of the first and middle thirds of the second and third temporal convolutions. The parts chiefly destroyed were the white matter of the third, to a less extent of the second, and to a still less extent of the fourth temporal convolutions. Internally the roof of the posterior horn presented a slightly-congested and granular appearance. The disease almost certainly started in the third temporal convolution, at a point with the posterior extremity of the horizontal branch of the Sylvian fissure. Microscopical examination showed the tumor to be a glioma.

In the discussion Dr. Mills said it was not unlikely that the case would be criticised, the separation of such an area for a naming centre having perhaps more opponents than advocates. However, the case gave strong evidence in its favor. The patient was not word-deaf. The first temporal convolution was intact. The second temporal convolution was not intact, but had evidently been involved in the progress of the disease. The upper portion of the second temporal convolution, the fissure between the first and second temporal, the occipital region, and the cuneus were not affected, nor was the anterior portion of the occipital lobe, except at the occipito, temporal junction. The hemianopsia was due to involvement of the optic radiations; it was not present when the verbal amnesia first appeared. He felt warranted in saying, from an examination of the specimen, that the tumor began in the third temporal convolution and then extended in different directions. Those who do not make a special study of localization sometimes get erroneous ideas of what is really meant by "idea," "concept," or "naming" centres, or centres of any kind for that matter. What is meant is, that here is a region to which converge the percepts from the different receptive centres of hearing, taste, sight, smell, touch, etc. Curiously this region is just the one so located anatomically as to receive with great facility impressions by way of association tracts which would come from the known receptive regions. A name arises in consciousness as a result of processes in this particular region. Ideation in a general sense is dependent upon the actions and interrelations of the entire cortex. This is the region for concrete names. A patient like the one reported will use abstract nouns, like love and hate, and put them in sentences.

Dr. F. X. Dercum stated that he was loth to regard any special area as a naming centre. It seems reasonable, however, that the various impressions received from the eye and ear should at some point be combined; but if this thought be pursued to its legitimate consequences the impressions from all of the senses must be included. He admitted, however, that the case reported was, clinically, very strong in favor of the view presented. It is not impossible nor improbable that there should be a centre in which impressions, especially from sight and hearing, are combined and symbolized.

Dr. Wharton Sinkler described a somewhat similar case which came under his observation several years ago. The patient, a woman 65 years of age, had violent occipital pain, which was so severe as to require the free

use of narcotics. With this there was complete left lateral hemianopsia. After two or three weeks the pain subsided and she apparently returned to her normal health, the hemianopsia still remaining. He then, by accident, discovered that she had, to a great extent, lost the power of naming objects. This was three or four years ago. She has since regained, to a certain extent, the ability to name objects, and appears to be in good health, with the exception of the hemianopsia.—*Journal of Nervous and Mental Disease*, February, 1895.

Selections from Reports of Members of the Annual's Staff of Correspondents.

Denmark.

DR. F. LEVISON,
REFERENT FOR DEN DANSK LITTERATUR VEDRÖRENDE: ALMINDELIG MEDICINSK PATHOLOGI OG THERAPI, DERI INDBEFATTET, NERVE- OG SINDSSYGDOMME, PÄDIATRIK, OBSTETRIK, GYNÄKOLOGI, HYGIEINE, DEMOGRAPHI, RETSMEDICIN, PATHOLOGISK, ANATOMI, BAKTERIOLOGI.

Alle medicinske Böger, Disputatser, Monographier, Tidsskrifter etc., der adkomme i Danmark bedes sendt til
DR. LEVISON,
Norrevoldgade, 13,
Köbenhavn.

Hæmorrhagic Pancreatitis.—KRAFT describes a case of hæmorrhagic pancreatitis the symptoms of which were sudden pains in the abdomen, vomiting of all food, and obstinate constipation. As no movement of the bowels could be effected by large injections of water, laparotomy was performed, and a brownish, turbid fluid was found in the peritoneal cavity, but no other signs of peritonitis; and, as close examination of the bowels showed no incarceration, the wound was closed. At the autopsy some signs of peritonitis were discovered, but the bowels were in a healthy condition. The liver was large and in a state of fatty degeneration. A large infiltration of blood around the pancreas extended to the base of the large omentum and into the ascending mesocolon, as well as into the retroperitoneal connective tissue. The pancreas was double its normal size and speckled with yellow and dark-red spots. Microscopical examination of its tissues revealed bloody infiltration and numerous leucocytes between the acini, which themselves were so degenerated in some places as to consist of a granular or almost homogeneous detritus containing but a few nuclei.—*Hospitals-Tidende*, p. 805, 1894.

Barlow's Disease.—HIRSCHPRUNG is reported as having observed, in the Children's Hospital at Copenhagen, 10 cases of Barlow's or Müller's disease; 6 of the patients were boys and 4 girls, the ages ranging from 5 months to 2 years, and all had evident symptoms of rachitis. The author gives a detailed description of each case and draws the conclusion that the disease is in no way connected with scurvy, but that it must be considered as an acute form of rachitis.—*Hospitals-Tidende*, p. 869, 1894.

Peculiar Effect of Chloral.—JACOBY observed several cases in which, after an ordinary dose of chloral, patients were peculiarly affected upon taking a moderate amount of stimulants, such as claret, this effect being

noticed if the stimulant were taken at once or the following day. It consisted in a sense of oppression with dyspnœa and congestion of the face. These symptoms were not observed after the use of chloral alone or wine alone.—*Hospitals-Tidende*, p. 748, 1894.

Exsiccative Diet in Ascites.—N. FINSEN recommends this method of treatment, especially in cases in which the origin of the ascites is dubious. He is himself a sufferer from the affection, and has repeatedly found relief after a few days' restriction, taking only 400 or 500 grammes (about a pint) of fluids daily. The urine increased in quantity and the symptoms of oppression disappeared. The method was still more efficacious if laxatives were used, or from 3 to 5 grammes ($\frac{3}{4}$ to $1\frac{1}{4}$ drachms) of chloride of ammonium.

Norway.

DR. F. LEVISON,

REFERENT FOR DEN DANSK LITTERATUR VEDRØRENDE: ALMINDELIG MEDICINSK PATHOLOGI OG THERAPI, DERI INDBEFATTET, NERVE- OG SINDSSYGDOMME, PÆDIATRIK, OBSTETRIK, GYNÆKOLOGI, HYGIEINE, DEMOGRAPHI, RETSMEDICIN, PATHOLOGISK, ANATOMI, BAKTERIOLOGI.

Alle medicinske Böger, Disputatser, Monographier, Tidsskrifter, etc., der adkomme i Danmark bedes sendt til

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Spontaneous Reposition of the Uterus.—VOGT observed a case of spontaneous involution of the uterus after acute inversion. A primipara of 42 years had been delivered by the aid of forceps, and the placenta had been expelled. Compression of the uterus and vaginal arch was made to arrest hæmorrhage, when the hand, introduced into the vagina, felt the uterus move and the fundus descend, while the other hand, applied to the abdomen, could feel no trace of the uterus. Hot water was immediately injected, when the uterus ascended, resuming its normal position.—*Norsk Magazin for Lägevidenskaben*, p. 647, 1894.

Post-mortem Appearances in Myxœdema.—K. GION performed an autopsy on a woman who had suffered for five years from myxœdema, and found that the median portion of the thyroid gland was completely atrophied and the lateral portions reduced to mere traces. The cerebral hypophysis was hypertrophied, being the size of a walnut, and entirely filling the sella turcica.—*Norsk Magazin for Lägevidenskaben*, p. 734, 1894.

Epidemic in an Insane Asylum.—HOLST describes a peculiar epidemic occurring in the Insane Asylum at Gaustad, characterized by fever, vomiting, diarrhœa, and attacking eighty-one persons, four of whom died. The onset was in many cases accompanied by rigors, and some patients showed herpetic eruptions. The symptoms pointed to poisoning from decomposed meat, but careful bacteriological examination revealed no such origin. The only point brought out was that the calf from which the meat was obtained had had diarrhœa a fortnight before being killed. In the spleen of three of the victims a bacillus was found which could be cultivated, either alone or with the staphylococcus albus. This bacillus greatly resembled the bacillus coli commune in some respects, but differed from it in not coagulating milk. —*Norsk Magazin for Lägevidenskaben*, p. 781, 1894.

Poland.

DR. J. DRZEWIECKI,

Redaktor Korespondent z działu polskiej literatury tyczącej się: Medycyny ogólnej i lecznictwa; pediatryi; akuszerzyi; ginekologii; laryngologii; otologii; hygieny; demografii; medycyny sądowej; histologii; patologii; bakteryjologii; anatomii; fizjologii

Wszystkie pisma lekarskie, dzieła, rosprawy, monografije, itd., w języku polskim wydane, a tyczące się przedmiotów powyższych, winny być nadsyłane pod adresem

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Parachlorophenol.—At the suggestion of NENCKI, A. ELSENBERG made a series of experiments with this drug in the treatment of lupus. Parachlorophenol [$C_6H_4Cl(OH)$] has the most powerful antiseptic action of any of the aromatic group. At the ordinary temperature of a room it consists of crystals; at 38° C. (100.4° F.) it is easily soluble in alcohol and ether and slightly so in water. Having carefully washed the lupous area with alcohol and afterward with ether, the author applied parachlorophenol with a brush, allowed an additional drop to remain on the ulcerated surfaces, and applied a cotton tampon soaked in chlorophenol. In order to augment and prolong the reaction he also applied, for from ten to twelve hours, a salve containing equal parts of parachlorophenol, lanolin, vaselin, and starch. The parts thus treated lost their milky whiteness after some hours, becoming red, swollen, and exuding serum from their surface. After twelve to twenty-four hours the transudation of serum ceased and a crust formed, which after eight or ten days could easily be taken off. After several applications of the remedy, the surface of the parts became equal and smooth and entirely covered with epithelium, the transudation diminished, the skin either returned to the normal state or, if the lupous changes were deeper, took the appearance of scar-tissue. The action of the remedy is very slow and accompanied by disagreeable symptoms, such as great pain and irritation of the conjunctiva and sclera. When used on the face it does not produce ulcers. The microscopical examination of the skin at various periods during the treatment proves that parachlorophenol destroys the superficial parts of the tissue of lupus, and in cases of deeper involvement occasions great inflammation, after the disappearance of which the degenerated parts of the structure become absorbed. Whether complete recovery takes place it is too soon to say, but its usefulness is indisputable.

I. SZMURLO used parachlorophenol, in the pure state as well as in 25- to 50-per-cent. solutions, in various diseases of the nose, pharynx, and larynx. In the pure state it was tried for hypertrophic affections, and in solution for tubercular ulcers. It does not possess the anæsthetic properties of phenol, while the smell and taste are exceedingly unpleasant. The results obtained were worse than from any other treatment employed.—*Gazeta Lekarska*, Nos. 10 and 12, 1894.

The Relation of Tuberculosis of the Skin to Tuberculosis of the Bones and Lymphatic Glands.—DR. DROBNIK calls attention to a form of lupus of the skin, appearing secondarily, as a consequence of tuberculosis in the bones or lymphatic glands lying nearest to the affected portion of the skin. The dependence of such lupus upon a primary affection is difficult to ascertain before an operation, and, even during operation, it may easily be over-

looked. There is always a tendency to considerable granulation and secretion of pus. Healing can only be effected by operation and removal of the primary focus. This form of lupus is most frequently observed on the neck, the lower jaw (in the deep system of submaxillary glands), on the arms, shoulders, and legs, though it may occur in other parts. Lupus accompanying an affection of the bones appears on the sternum, the dorsal part of the feet, the hands, and tibia. The author has never seen it in the vicinity of large joints.—*Nowiny Lekarskie*, No. 3, 1894.

Changes in the Respiratory Organs in Carbolic-Acid Poisoning.—LEON WACHHOLZ reports two cases of suicidal poisoning with carbolic acid in which post-mortem examination showed, among others, changes in the respiratory organs. That carbolic acid occasions certain anatomical changes in these organs has been long known, but the explanation of such changes, however, has been unsatisfactory. To elucidate the question the author undertook a series of experiments on animals, from which he draws the following conclusions:—

1. Carbolic acid is absorbed into the blood, whence it is violently eliminated by the kidneys, occasioning necrobiotic changes in those organs.

2. It effects the respiratory organs in the same manner as preparations of mercury do the bowels.

3. The course of the poisoning in man and warm-blooded animals differs in that, in the latter the period of excitation predominates, while coma and paralysis develop in man at the outset.—*Przeglad Lekarski*, Nos. 21, 23, 24, 1894.

Ichthyol in Pharyngitis.—E. SONENBERG describes four cases of acute pharyngitis in which he used with success a 2- to 3-per-cent. solution of ichthyol. From these and forty other recorded cases he recommends the use of the drug as a gargle every ten to fifteen minutes.—*Medycyna*, No. 23, 1894.

Sweden.

DR. F. EKLUND,
Brefvixlande Medarbetare
för den
SVENSK MEDICINSK
LITTERATUR.

Af alla i Sverge utkommande medicinska tidskrifter, bocker, afhandligar, monographier a. s. v. torde ett exemplar benäget öfversändas till

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Simple Method of Detecting Bile-Pigment in Icteric Fluid.—ISRAEL HEDENIUS recommends the following method: To about 5 cubic centimetres ($1\frac{1}{4}$ fluidrachms) of the serous fluid add twice or three times its volume of concentrated alcohol and shake the mixture. Add as many drops of hydrochloric acid (10 to 25 per cent.) as will be required to dissolve the precipitation caused by the addition of the concentrated spirits, when the fluid will become clear. Bring the fluid to a boil, and if gall-pigment be present a blue-green color will appear within a minute or so. In a serous exudation containing only 1 part of bilirubin to 250,000 parts of fluid, the blue-green color became very conspicuous. When it is desired to ascertain the presence of an insignificant quantity of the coloring matter of

the bile in concentrated fluids rich in albumin, the author proceeds as follows: To 3 or 4 cubic centimetres ($\frac{3}{4}$ to 1 fluidrachm) of the fluid add four or five times its volume of concentrated spirit, which will cause the precipitation of all the proteid substances present. Shake well several times and filter the fluid. Add several drops of hydrochloric acid and boil, when, if gall-pigment be present, a delicate blue-green color will appear in the fluid.

To test the blood precipitate 2 to 4 cubic centimetres ($\frac{1}{2}$ to 1 fluidrachm) with the aid of 10 to 20 cubic centimetres ($2\frac{1}{2}$ to 5 fluidrachms) of concentrated spirits and shake well several times. To 10 cubic centimetres ($2\frac{1}{2}$ fluidrachms) of the percolated fluid add about 5 drops of hydrochloric acid (preferably 10-per-cent. strength) and boil. The blood must be fresh, and frozen blood should not be used. In order to make the reaction perfectly plain the blood must contain not less than 1 to 50,000 bile-pigment. As to the urine, it is important that this be diluted with at least four volumes of concentrated spirits.—*Upsala lakäreförenings forhändlingar*, vol. xxix, Nos. 7, 8.

Alterations in the Liver After Ligature of the Hepatic Artery.—JANSEN describes the changes in the liver after ligature of the hepatic artery in the dog. Multiple necrosis occurs and cysts develop in the larger portions, while the smaller are transformed into connective tissue, causing, with the bile-stasis present, a sort of cirrhosis. In this cirrhosis the development of connective tissue is the primary change, and atrophy of the parenchyma the secondary. The pseudobiliary ducts met with in large numbers are biliferous and communicating with the preformed gall-ducts, and the trabeculæ of the liver-cells are dilatated gall-capillaries surrounded by atrophied liver-cells. The orifices in the parenchyma of the liver are produced by gall-stasis and the consequent necrosis of the liver. The author observed many newly-formed cells, but few mitoses. New biliary ducts are formed, mitoses being present in great abundance in the connective tissue. If necrosis attain a considerable degree, it continues progressively until death.—*Nordiskt medicinskt arkiv*, vol. xxvi, No. 34.

Vaselin in Erysipelas.—H. KÖSTER, of the Sahlgren Hospital, has made a study of the relative value of the various common methods of treatment of erysipelas. The duration of the fever appeared to be the same when vaselin was used as when Goulard's water, iodine applications, ichthyol and vaselin, and sublimated lanolin were employed. None of these remedies were capable of checking the process with certainty, and in exceptional cases this spread over almost the whole surface of the body. The complications, especially the phlegmonous process, did not appear to be greater after the use of vaselin than when other measures were used. Consequently the author regards vaselin as quite as efficacious as the other well-known topical remedies, and preferable because inoffensive, cheap, without disagreeable odor, and producing no irritation.—*Upsala lakäreförenings forhändlingar*, vol. xxx, No. 2.

Clinical Notes.

The Kidneys in Gout.—Dr. F. Levison, in a contribution to the study of gout, shows that all recent investigations prove the correctness of the theory of Horbaczewski, that uric acid is a product of nuclein, and that its formation is proportionate to the amount of leucocytes formed and destroyed in a given time. This explains the fact that the blood is loaded with uric acid in leucocythæmia, pneumonia; in the first days of infancy, etc., but it does not explain why the blood of arthritic patients contains more uric acid than normal blood. This, it seems, is due to the retention in the blood of uric acid by a deficient functional action of the kidneys.

All authors agree that the kidneys are very often affected in gout, becoming small and red, though it is commonly asserted that this alteration is not constant. In all cases in which autopsies are reported, however, the kidneys have been found in the above condition. Ebstein quotes two instances of gout with healthy kidneys, but these cases do not prove anything, as they were observed at a period (in 1824, by Dufresne and Fauconneir, and, in 1845, by Bramson) when it was not the custom to examine the kidneys, and the authors merely state that the urinary organs were found to be healthy, making no special mention of the kidneys. It is consequently justifiable to maintain that in this disease the kidneys are always affected, and also that they are always in a state of granular atrophy.

In order to ascertain whether this state of the kidneys is to be considered as the origin of gout, Dr. Levison has collected the results of a series of necropsies (at most of which he was present) on patients who had not been under treatment for gout, and most of whom had presented no evident symptoms of disease of the joints, but who had been suffering from differet diseases of the kidneys.

The metatarso-phalangeal joint of the hallux was examined in all the cases, and sometimes other joints, and uratic deposits were found in all of twelve cases of primary granular atrophy of the kidneys, while in thirty cases of other renal diseases the joints were healthy. The patients with uratic deposits had followed various occupations; some of them had been exposed to the action of lead (plumbers, file-cutters, and others), and some had even presented evident signs of lead poisoning. The development of gouty deposits seems thus to presuppose the existence of a granular atrophy of the kidneys and the storing up of uric acid in the blood, where it is retained long enough to be changed from the soluble quadriurate into the biurate which is precipitated in the joints. (Roberts.) It is easily understood that primary granular atrophy of the kidneys may cause a retention of uric acid, as this disease, whether it be occasioned by lead poisoning or by the precipitation of uric-acid crystals in the tubules, always commences by an alteration of the epithelial cells of the convoluted tubules, and is only much later complicated by the formation of new connective tissue, which ultimately retracts.

Atrophy of the kidney does not invariably occasion a retention of uric acid; the senile, the arterio-sclerotic, and the secondary atrophic kidney do not produce this effect, but they are easily distinguished from primary atrophy.

Syphilitic atrophy, which is also without influence on the production of gout, and which is more difficult to distinguish, is ordinarily asymmetrical, either affecting only one kidney or some portions of both, the balance remaining almost healthy; it takes its origin from an affection of the vascular system of the kidneys, and not of the glandular elements, and even in old cases the secreting cells may in many parts be found healthy. The author draws the conclusion that gout is not so uncommon a disease in Denmark as was formerly believed, that it is always combined with primary renal atrophy, and that this latter condition is, in all probability, indispensable to the development of gouty deposits.—*Zeit. für klin. Med.*, p. 283, 1894.

The Treatment of Gastric Ulcer.—Dr. Guthrie Rankin, of Warwick, Eng., gives the details of a series of ten cases in which the combined use of papain, iron, and cannabis Indica was followed by satisfactory results. It would seem doubtful, according to the author, whether many cases of so-called irritative dyspepsia may not in reality be due to a definite lesion of the mucous membrane in a latent condition. Hæmatemesis is not necessarily present in every case of even acknowledged gastric ulcer, and in its absence it must always be a matter of difficulty to decide whether the train of symptoms owes its cause to a simple catarrh or to organic change in the substance of the stomach-wall. The occurrence of hæmorrhage clinches the diagnosis; but where remedies, useful in cases about which by reason of the hæmatemesis there can be no doubt, give equally-good results in allied cases which fall short of the confirmatory evidence afforded by the bleeding, it may be assumed that such cases may owe their symptoms either to an early stage of the same condition or to an accomplished lesion of the surface so chronic and indurated as to prevent actual loss of blood. By some observers the persistence of pain in patients who have admittedly suffered from gastric ulcer has been ascribed to imperfect movement of the stomach-walls consequent upon the interference of the resulting cicatrix; but the histories of four of the cases would rather indicate either imperfect healing or the occurrence of another patch of ulceration as the more probable explanation of the continuance of this symptom. Were this not so it is hardly conceivable that each of these cases could have recovered so thoroughly, because it seems certain that in several of them there must have remained one or more cicatrices of considerable dimensions. As the large proportion of such ulcerations occur in anæmic patients, the *raison d'être* of the iron is manifest. It may be that in some cases iron is not indicated at all by the existence of any appreciable anæmia; but even then it is probable that the blood is impoverished to some degree, and that the hæmatinic properties of the drug not only restore this depreciation of quality, but also, in a secondary way, promote the healing process at the site of lesion. The cannabis Indica is useful as a sedative to the stomach-walls, as a controller of its muscular action, and as a prop to its nerve-supply, while it is also fully recognized as a direct promoter of appetite. Lastly, papain, which is the most important member of the trio, probably has a complex effect on the curative process. It is well known that when a solution of papain is painted over a fissured or ulcerated tongue it rapidly provokes cicatrization.

The drug is also of value as a speedy solvent of dead tissue, and to some extent it is credited with antiseptic and tonic properties. Its great use, however, medicinally, has hitherto been as a digestive ferment, and its activity in this respect would seem to exceed that of pepsin, pancreatin, or any other known agent. If all these powers of papain be admitted it is easy to canceive a reasonable hypothesis to explain the happy results afforded by it in cases of gastric ulcer, particularly when it is combined with other drugs such as those indicated, which by their collateral effect assist and intensify its action. This hypothesis is strengthened by the post-mortem evidences in one case and still further confirmed by the marked alleviation, if not permanent cure, in the others.—*Lancet*, February 9, 1895.

Management of Typhoid Fever.—Prof. F. C. Shattuck, of Boston, has for the past two years given to typhoid patients, who seem able to bear them, raw and very soft boiled eggs, custards, animal broths, strained gruels, ice-cream, junket, blanc-mange, and even scraped or very finely minced meat, in addition to their milk, watching the stools, of course, for the appearance of undigested food. He believes in giving as much and as wide a range of food as each individual patient can digest, and as will not prove irritating to the ulcerated intestine, with plenty of water internally to promote the elimination of soluble poisons. He does not regard with much favor the use of the so-called intestinal antiseptics, and prefers small doses of the salicylate or subgallate of bismuth, the astringent properties of these compounds being naturally taken into account in their administration. He often gives a preliminary dose of calomel, especially in cases seen early and without pronounced diarrhœa. He resorts to enemata of water every second day when there is constipation, and to morphia to mild narcotism where there is intestinal hæmorrhage. He does not approve of controlling the fever by means of drugs, and only now and then gives an occasional antipyretic dose in cases in which the headache or pyrexia produces such discomfort as to warrant it. Phenacetin he believes to be the safest of these remedies.

He has used the Brand method in hospital practice, and of 236 cases treated expectantly and with cold spongings 23 died,—a mortality of 10 per cent. For some years past the cold spongings have been made much more efficient in the Massachusetts Hospital by rolling up the rubber sheet placed immediately under the patient at the sides so as to form a trough. Water at 60° F. (15.6° C.) is used, sometimes water with a little ice in it to make up for the heat absorbed from the body. One attendant can use cold water in this way, while two are almost indispensable for the tub-bath, with affusion to the head and friction to the body. A temperature of 102.5° F. (39.2° C.) is regarded as an indication for cold water.—*Boston Medical and Surgical Journal*, December 20, 1894.

Case of Acute Alcohol Poisoning.—Dr. Norman Kerr, of London, describes the case of a woman, aged 41 years, wife of a laborer, a periodic inebriate, who drank 1½ pints (750 cubic centimetres) of whisky 22 over proof (47 stronger than whisky as usually retailed). As this is nearly double the ordinary retail spirituous strength, she must have swallowed more than 2¾

pints (1375 cubic centimetres) of the latter. In a few minutes she was found lying on her back insensible, and never recovered consciousness till she died, five and a quarter hours later. The post-mortem appearances thirty hours after death were: venous engorgement of the head, with subarachnoid effusion, in addition to old-standing congestion, with white, milk-like film on the surface of the pia mater. The walls of the heart were fatty, pale, and thickened. The cavities contained about ½ ounce (15 cubic centimetres) of fluid, tarry-like blood in the right ventricle. There was slight pleural effusion in the lungs, and patches of extravasation of blood in both. The walls of the stomach, which were thinned in parts, with patches of mucous membrane semi-detached, presented brownish-black ridges, with a red, fiery, tree-like aspect, on a translucent, pale, interspersed with red ground, corrugated inflammatory appearances extending into the duodenum. The stomach contained 8 ounces (250 cubic centimetres) of grumous fluid with a faint odor of alcohol. The spleen was engorged. The capsule of the kidneys was semi-adherent. While the patient was alive the face was pale, the eyes suffused and dull; the skin cold and clammy, with cold perspiration; the pulse thin and compressible, almost imperceptible; and the breathing stertorous. Throughout the pupils were dilated. The temperature fell 7° F. (3.88° C.) below normal.—*Lancet*, February 16, 1895.

Liquor Cannabis Indica.—R. Cowan Lees, of Glasgow, has had excellent results from the use of a strong aqueous extract of the flowering tops of the female plant, of the usual strength of liquid extracts. It possesses the anodyne and soporific action generally ascribed to the resinous extract, although in a modified degree. It has the characteristic odor of the hemp, a beautiful deep-amber color, is miscible with water, and hence there is no difficulty in combining it with other liquids

Liquor cannabis Indicæ in his experience gives all the beneficial effects without the drawbacks of the tincture, avoiding those extreme exhilarating conditions bordering on intoxication, which are sometimes met with even when using a medium dose of the latter. It does not seem to interfere with the secretion of mucus from the bronchial glands,—a circumstance which renders it superior to opium in cases suitable for its use, whilst in pulmonary affections generally it acts most favorably as a soporific and anodyne.

The author speaks very highly of its effect in phthisis, where it relieves the cough and stimulates and exhilarates the patient. It is also valuable in indigestion and constipation. The dose commonly used by him was ½ fluidrachm (2 grammes) for an adult, though in many cases it may be increased to 1 drachm (4 grammes). The dose for children is proportionate, though Dr. Lees observed that young patients were somewhat less susceptible to it than grown persons.—*British Medical Journal*, February 9, 1895.

Ferripyrin.—This new hæmostatic, introduced by L. Hedderich, is a combination of perchloride of iron and antipyrin, the formula being Fe_2Cl_3, $3\ (C_{11}H_{12}Az_{20})$. It is a fine orange-colored powder, soluble in water, the solution being deep red in color. It is intended as a substitute for per-

chloride of iron, and the indications for its use are the same. The dose for an adult is 0.5 gramme ($7\frac{3}{4}$ grains) internally, mixed with an oily, sweet preparation of menthol. It is of value in gastrorrhagias. For external use and as an hæmostatic, either the powder or an 18- to 20-per-cent. solution may be employed, cotton tampons being saturated in the solution and applied to the bleeding surface. In 1- and $1\frac{1}{2}$-per-cent. solutions it is recommended as an astringent in urethral blennorrhagia. Epistaxis in a case of nasal myoma was arrested by the author in a very short time by the introduction of two small tampons soaked in ferripyrin. The drug is free from the caustic effects produced by perchloride of iron.—*Münch. Med. Woch.*, No. 1, 1895.

Diagnosis of Purulent Diaphragmatic Pleurisy.—Dr. P. Merklen has observed, as the characteristic signs of many cases of purulent diaphragmatic pleurisy, a dullness of the antero-inferior portion of the thorax, the upper boundary of this dullness forming a concave line inferiorly; a downward displacement of the liver if the affection be right-sided; a displacement of the heart to the right if the effusion be on the left side. Associated with the usual functional symptoms of the disease, these signs are of value in the diagnosis and in surgical intervention. A differential diagnosis between this affection and subphrenic abscess can be made from the manner of onset—diaphragmatic pleurisy beginning with pulmonary symptoms and subphrenic pyothorax with gastro-intestinal symptoms, as vomiting and diarrhœa—and, if necessary, by exploratory puncture.—*Presse Médicale*, February 2, 1895.

Recurrence of Scarlet Fever within One Year.—Dr. John B. Crandall, of Sterling, Ill., records an unusual case in which scarlet fever appeared twice during the same year. In March, 1894, he treated a girl, of 12 years, for an attack which followed the ordinary course, with exfoliation of the derma. The convalescence and recovery were without complications. The rest of the family were isolated and escaped. In November he was called to attend her again, and watched the case from the early fever to the formation of the scarlet rash, the symptoms—strawberry tongue, exfoliation, etc.—being marked, though the throat symptoms were not so prominent as in the first attack. In hundreds of cases Dr. Crandall has never had a similar experience.—*Medical and Surgical Reporter*, January 26, 1895.

Trional.—Goldmann regards this drug as the most desirable of hypnotics, owing to the rapidity of its action, which is without any bad effects. It should always be given with a considerable quantity of hot fluid. If not carefully administered hæmatoporphyrin may appear in the urine, which should be carefully watched. Bicarbonate of sodium (4 to 6 grammes—1 to $1\frac{1}{2}$ drachms) should be given in case the urine becomes cloudy, and the patient should drink large quantities of aërated water. The dose of trional should not exceed 2 grammes ($\frac{1}{2}$ drachm); usually 1 or 1.5 grammes ($15\frac{1}{2}$ to $23\frac{1}{4}$ grains) will be sufficient. It should be suspended from time to time, and citric acid given to facilitate its elimination.—*Therapeutische Monatshefte*, No. 11, 1894.

Disinfection of Tubercle-Infected Houses.—DRS. DELÉPINE and RANSOME, of London, have made an extended study of the various methods of disinfection and the influence of certain natural agents on the virulence of the tubercle bacillus. They sum up their results as follows:—

1. The disinfection of rooms which have been contaminated with tuberculous products cannot be obtained by means of the fumigation methods generally used at present. Sulphurous acid, chlorine, and euchlorine, as used under supervision by experienced municipal disinfectors, have proved practically useless. This only confirms the results obtained by Koch and his pupils in the case of a number of other organisms.

2. The only other method of disinfection which seems to promise more satisfactory results is the direct application of a solution of chlorinated lime to the walls to be disinfected. This method has so far given satisfactory results, but is attended with discomfort on the part of those who have to carry out the disinfection, though this difficulty may be overcome. It must be remembered that the experiments of Schill and Fischer are unfavorable to the use of perchloride of mercury.

3. Light is, in the case of the tubercle bacillus, as it has been proved by several observers to be in the case of other organisms, the most important natural disinfecting agent.—*British Medical Journal*, February 16, 1895.

Resorbin.—This is an emulsion containing oil of sweet almonds, wax, gelatin, soap, and lanolin, and resembling butter in appearance. LEDERMANN has used it in a number of cases of skin disease, and finds that it penetrates the skin very rapidly when even slight friction is used.

Recent Suggestions in Therapeutics.

Acute Coryza.—*Abortive treatment:* Pure *carbolic acid*, *ammonia*, each 5 grammes (1¼ fluidrachms); *alcohol* (90 per cent.), 10 grammes (2½ fluidrachms); *distilled water*, 15 grammes (3¾ fluidrachms). Pour 10 drops on blotting-paper every hour and inhale for several seconds. This is a modification of Brandt's formula. Abortive powder: *Cocaine hydrochlorate*, 0.50 gramme (7¾ grains); *menthol*, 0.25 gramme (4 grains); *salol*, 5 grammes (1¼ drachms); *boric acid*, 15 grammes (3¾ drachms). Use hourly as a snuff. Internally give *tincture of belladonna* and *alcoholic extract of fresh aconite-root*, equal parts, 30 drops, in two doses. To cause perspiration, vapor-bath. *Palliative treatment:* To restore nasal permeability, boiled solution of *cocaine hydrochlorate*, 1 to 100, lukewarm; or, if there is an idiosyncrasy to *cocaine*, spray of pure *olive-oil*, 20 grammes (5 fluidrachms); *menthol*, 1 gramme (15½ grains). To relieve trigeminal neuralgia, chill, and lassitude: *quinine hydrochlorate*, 0.25 gramme (4 grains); *antipyrin*, 0.50 gramme (7¾ grains). (MARCEL LERMOYEZ, *Jour. des Praticiens*, January 26, 1895.)

Asystole in Children.—Give as a purgative, German *brandy*, 5 to 10 grammes ($1\frac{1}{4}$ to $2\frac{1}{2}$ fluidrachms); *syrup of buckthorn* or *senna*, 5 to 10 grammes ($1\frac{1}{4}$ to $2\frac{1}{2}$ fluidrachms). For a child from 5 to 10 years old. If purgation is not accomplished, give following injection: *boiling water*, 250 grammes (8 fluidounces); *sodium sulphate*, *senna-leaves*, each 10 grammes ($2\frac{1}{2}$ drachms). To produce diuresis, prescribe *powder of digitalis-leaves*, 0.20 gramme (3 grains); infuse two hours in *boiling water*, 100 grammes ($3\frac{1}{4}$ fluidounces); add *syrup of digitalis*, 20 grammes (5 fluidrachms). A teaspoonful every two hours for four or five days. Interrupt administration for a similar period and begin again if necessary. In urgent cases give the following instead: *Caffeine*, *sodium benzoate*, each 1 gramme ($15\frac{1}{2}$ grains); *orange-flower water*, 10 grammes ($2\frac{1}{2}$ fluidrachms); *syrup of coffee*, 30 grammes (1 fluidounce); *water*, 60 grammes (2 fluidounces). A teaspoonful every hour or two, as required. At the same time add from 40 to 50 grammes ($1\frac{1}{4}$ to $1\frac{1}{2}$ ounces) of *lactose* to the *milk* used, to increase its diuretic action. If the child prefer a tea, give an infusion of *cherry-stems*; or a decoction of *triticum nepens*, containing 2 to 4 grammes ($\frac{1}{2}$ to 1 drachm) of *sodium nitrite* to the litre (quart); or 10 grammes ($2\frac{1}{2}$ drachms) of *juniper-berries* infused in 150 grammes (5 fluidounces) of *boiling water*. Strain and add *acetate of potassium*, *nitrate of potassium*, each 1 gramme ($15\frac{1}{2}$ grains); *oxymel of squill*, 15 grammes ($3\frac{3}{4}$ fluidrachms). Preparations of squill contra-indicated in albuminuria. (J. COMBY, *Médecine Moderne*, February 13, 1895.)

Bromalin (Bromethylformine).—A substitute for *inorganic bromides*. Formula: $(CH_2)_6N_4C_2H_5Br$. It contains 32.13 Br, 67.2 KBr. Two grammes ($\frac{1}{2}$ drachm) equal 1 gramme ($\frac{1}{4}$ drachm) ordinary *bromides* in reducing number of fits in epilepsy. May be employed in much larger doses than ordinary *bromides*. One epileptic patient took about 8 grammes (2 drachms) daily for six weeks without manifesting any skin eruption or other untoward effects. Appetite remained good. Author confirms the good effects obtained by Féré in epilepsy. Dose for adults: 10 grammes ($2\frac{1}{2}$ drachms) divided in 10 parts, daily. For children: 10 grammes ($2\frac{1}{2}$ drachms) dissolved in *distilled water* 10 grammes ($2\frac{1}{2}$ drachms); *syrup of bitter orange-peel*, 90 grammes (3 ounces). A teaspoonful twice daily. (LAQUER, *Neurol. Cent.*, January, 1895.)

Disinfectant for the Sick-Room.—*Sulphate of zinc*, 1000 grammes (2 pounds); *sulphuric acid*, 5 to 10 cubic centimetres ($1\frac{1}{4}$ to $2\frac{1}{2}$ fluidrachms); *essence of mirbane* (*nitrobenzol*), 2 cubic centimetres ($\frac{1}{2}$ fluidrachm); coloring matter, *e.g.*, *indigo blue*, 0.15 gramme ($\frac{1}{4}$ grain). Place about 5 grammes ($1\frac{1}{4}$ drachms) in bed-pan before using. Contact with urine or liquid stools determines prompt solution of this salt, deodorization and sterilization being instantaneous. The excreta are also thus preserved for microscopical examination. (MEILLÈRE, *Lancet*, February 9, 1895.)

Epithelioma of Face.—Formula for Marsden's paste: *Arsenious acid*, 2 drachms (8 grammes); *pulverized gum arabic*, 1 drachm (4 grammes); *cocaine muriate*, 18 grains (1.17 grammes). When desired for use add water to make into a paste the consistency of soft cheese. Apply on a small piece of cloth and leave on for thirty-six hours. One application usually sufficient. If necessary apply a second time, removing scab if any has formed. In mild case use paste half the strength of above. (J. A. WYETH, *Inter. Jour. of Surgery*, January, 1895.)

Exophthalmic Goitre.—*Salicylate of sodium*, 4 to 5 grammes (1 to 1¼ drachms) every twenty-four hours, in four doses. Given in ½ litre (1 pint) of fluid to prevent intolerance. Four cases successfully treated by author, who calls attention of practitioners to value of method. (CHIBRET, *Revue gén. d'ophtalmologie*, January 31, 1895.)

Gouty Furunculosis.—*Extract of colchicum*, 0.02 to 0.03 gramme (⅓ to ½ grain) daily. Valuable in cases in which diabetes and albuminuria do not exist. (BROCQ, *Jour. de Méd. et de Chir. Prat.*, February 10, 1895.)

Hæmoptysis.—*Calcium chloride* (the pure crystallized salt), 10 to 15 grains (0.65 to 1 gramme) every two hours, in *glycerin*, simple elixir and water, or in infusion of *gentian*, 10 grains (0.65 gramme) to the teaspoonful. Reduce frequency of dose as improvement takes place. (S. SOLIS-COHEN, *Philadelphia Polyclinic*, January 19, 1895.)

Neurasthenia.—*Hydrochlorate of cocaine*, 0.02 gramme (⅓ grain); *vanilla-sugar*, 1 gramme (15½ grains). Give two or three times daily in a glass of milk. Give also the following: *coca-wine*, 1 litre (1 quart); *tincture of nux vomica*, 2.50 to 5.00 grammes (¾ to 1¼ fluidrachms); *quassia-extract*, 5 grammes (1¼ fluidrachms). A small wine-glass at the two principal meals. Given in this manner, the *cocaine* leads rapidly to regularity in sleep, increase of strength, and disappearance of the feeling of prostration. (GELEY, *Journal de Méd. et de Chir.*, November 10, 1894.)

Neurotic Dyspepsia.—Take of *potassium cyanide*, 1 grain (0.065 gramme); *extract of valerian*, 36 grains (2.33 grammes). Make into 12 capsules. Dose: One capsule thrice daily, after food. Or, *silver nitrate*, ⅙ grain (0.01 gramme) thrice daily, alone or combined with *strychnine*. Of value in case of apparently ordinary flatulent dyspepsia not benefited by usual treatment. (J. P. CROZER GRIFFITH, *Philadelphia Polyclinic*, January 5, 1895.)

Phthisis.— ℞ *Phenacetini*, 40 grains (2.60 grammes); *strychninæ sulphatis*, 1 grain (0.065 gramme); *ammonii chloridi*, 1 drachm (4 grammes); *quininæ sulphatis*, 32 grains (2.07 grammes); *pulvis capsici*, 10 grains (0.65 gramme); *pulvis digitalis*, 6 grains (0.39 gramme); *ferri sulphatis*, 20 grains (1.3 grammes); *atropinæ sulphatis*, $\frac{1}{30}$ grain (0.002 gramme). M. ft. capsulæ no. xxxii. Sig.: One capsule four times a day. Serviceable prescription which has stood the test of time and experience in the author's hands. (THOMAS J. MAYS, *Philadelphia Polyclinic*, January 26, 1895.)

Puerperal Sepsis.—After first chill and rise in temperature, give hot vaginal douche containing *creolin*, 1 drachm to 1 pint (4 grammes to ½ litre), or *corrosive sublimate*, 1 to 4000, every four hours. If temperature is not normal in twenty-four hours, curette uterus with Braun's dull douche-curette, thus thoroughly flushing out with antiseptic fluid. Insert suppository containing 40 to 60 grains (2.60 to 4 grammes) *iodoform* in *cocoa-butter*. (E. P. DAVIS, *Philadelphia Polyclinic*, January 19, 1895.)

Ready Means of Procuring and Transmitting Diphtheritic Discharges for Examination.—Fit an ordinary three-quarter-inch wide test-tube with a tight plug of cotton; into this plug of cotton insert the end of the cedar-wood handle of a small goat's hair brush. The handle should not come quite through the plug, but be securely tied to the superfluous cotton at the mouth of the tube; the brush should reach close to, but not be in actual contact with, the deepest part of the tube. If desired to prevent evaporation cover the tube with a loose caoutchouc cap. Sterilize the tube with the inclosed brush in the hot-air chamber and attach a label with spaces for name of patient, date of removal of specimen, duration of disease, and name and address of practitioner. Fit the tube into a small, padded box with an address-label attached. All that the practitioner has to do is to withdraw the plug with the attached brush (to which it forms an excellent handle) while the mouth of the tube is held downward, to scrape off some of the membrane from the affected parts with the brush, to replace the cotton plug and attached brush in the tube, and send the box for examination. In starting a culture on blood-serum or other basis the brush from the tube is rubbed over the surface of the medium. The advantages which the method possesses are: (1) that the discharge is removed by and received in sterilized instruments; (2) that the brush is an excellent means of collecting the discharge and does not alarm the patient by its appearance; (3) that no time is lost in transmission; (4) that the brush is again an excellent instrument for spreading the discharge over the surface of the culture-basis; and (5) that the cost of the apparatus is trifling. These sterilized tubes could be kept by local apothecaries and be had on a moment's notice. They are of small bulk; so that they can readily be carried about when required. (PROF. D. J. HAMILTON, Aberdeen University, *British Medical Journal*, February 9, 1895.)

Simple Test for Sugar in Urine.—Place 1 drachm (4 grammes) of urine in a test-tube about one-half inch in diameter; add 1 drachm (4 grammes) of a saturated, aqueous solution of *picric acid* and ½ drachm (2 grammes) of *liquor potassæ* (P. B.). An orange-red color instantly appears as a result of the incipient reducing action of *creatinin* upon *picric acid* at the ordinary temperature. If, after the liquid has been kept at the boiling-point for about a minute, a bright-red color appear through the test-tube when held up to the light, the urine may be confidently pronounced free from sugar. No other method as easy and rapid for clinical and life assurance purposes. (SIR GEORGE JOHNSON, *Lancet*, January 12, 1895.)

Sterilization of Cotton-Wool.—At moment of using dip tampon of cotton in *boric alcohol*, and hold over flame of an alcohol-lamp for several seconds. Sterilization is perfect, without any alteration or loss of hydrophilic properties. (LERMOYEZ and HELME, *Annales des Mal. de l'Oreille*, January, 1895.)

To Disinfect Typhoid Stools.—*Sulphate of copper*, *sulphuric acid*, each 10 grammes (2½ drachms); for 1000 cubic centimetres (quart) of fæcal matter. Kills typhoid bacillus in one hour, at temperature of 15° C. (59° F.) (H. VINCENT, *Semaine Médicale*, February 6, 1895.)

Uterine Hæmorrhage.—Dilate the uterus without *chloroform*, curette, and pass a fenestrated sound into the uterine cavity, containing a metal tube of small calibre. Connect this with an apparatus giving off steam at about 212° F. (100° C.), turning off the steam in one minute, when hæmostasis will be complete. The patient feels no pain, the part becomes insensitive, fœtor is destroyed, and the mucous membrane is covered with a thin albuminous pellicle. (ZACHARIN, *Rép. Univ. d'Obstet. et de Gyn.*, October 25, 1894.)

Vaginitis in Children.—*Tincture of belladonna*, 1½ fluidrachms (6 grammes); *spirit of nitrous ether*, 3 fluidrachms (12 grammes); *Camphorated tincture of opium*, 4 fluidrachms (16 grammes); *tincture of buchu*, sufficient to make 3 fluidounces (90 grammes). Mix. Dose: Half a teaspoonful, increasing to a full teaspoonful, in a little water, every two or three hours. Give 20 to 30 grains (1.3 to 2 grammes) *sodium bicarbonate* after each meal, with flaxseed-tea or other demulcent drinks. (HOMER C. BLOOM, *Philadelphia Polyclinic*, February 2, 1895.)

Monographs Received.

The editor acknowledges, with thanks, the receipt of the following monographs:—

Transactions of the Clinical Society of London. Vol. xxvii. 1894.——Medico-Chirurgical Transactions, published by the Royal Medical and Chirurgical Society of London. Vol. lxxvii, 1894. London.——Blood-Serum Therapy and Antitoxins, by **George E. Krieger**, Chicago, Ill.——A Case of Cholecystotomy for Obstructive Jaundice, by **R. Whiteman**, Shakespeare, Ont.——Removal of the Head of the Femur from the Lesser Sciatic Notch, by **B. Merrill Ricketts**, Cincinnati, O.——Conseils Professionnels et Principes de Déontologie Médicale. Association des Médecins de la Gironde. Bordeaux, 1895.——Altes und Neues über Kranke Lymphdrüsen, von **Carl Bayer**, in Prag, 1894.——Trabajos é Instrumentos presentados en la Sección de Laringologia del XI Congresso Medico Internacional de Roma, por el **Ricardo Botey**, Barcelona, 1894.——Third Annual Report of the Sheppard Asylum, a Hospital for Mental Diseases, Baltimore, Md., 1895.——Reports from the Laboratory of the Royal College of Physicians, Edinburgh, edited by **J. Batty Tuke** and **D. Noel Paton**. Vol v, Edinburgh, 1894.——Intestinal Anastomosis, by **Frederick Holme Wiggin**, New York, 1894.——Trattato di Patologia Speciale Medica e Terapia ad uso degli Studenti e dei Medici, par **Temistocle Santopadre**. Vol. i, Fasc. 2. Ferrara, 1894.——Caries of the Spine followed by Compression of the Cord, by **J. T. Eskridge**, Denver, Col., 1894.——Notes on a Few Clinical Experiences of Inherited Syphilis; Seborrhœa. By **Burnside Foster**, St. Paul, Minn., 1894.——Diphtheria: Observations on its History and Progress in New Orleans, by **Joseph Jones**, 1895.——Causas que sostienen la Endemicidad de la Fiebre Amarilla en la Habana, por el **Enrique Acosta**, Habana, 1894.——Woman's Medical College of Pennsylvania, Forty-fifth Annual Announcement, May, 1894.——Malattie Predominanti nei Paesi Caldi e Temperati, por **Fillipo Rho**, Roma. 1895.——Treatment of Club-Foot by Wolff's Method, by **A. R. Shands**, Washington, D. C., 1894.——Reminiscences of Dr. J. Marion Sims, by **Edmond Souchon**, New Orleans, La., 1894.——Colotomy and the Kraske Operation, by **B. Merrill Ricketts**, Cincinnati, O., 1894.——J. Rollet; Éloge Nécrologique, par **L. Jullien**, Paris, 1894.

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(End of Editorial Department of Journal for March, 1895.)

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Salophen as an Antirheumatic.

Drs. de Buck and Vanderlinden calls attention to the fact that, while the antirheumatic properties of Salophen in acute articular rheumatism have been demonstrated by many authors, much less has been written with regard to its analgesic effects. Excellent results have been obtained from the remedy in the extensive domain of painful affections of the nervous system, such as cephalalgia, hemicrania, pleurodynia, neuritis. In view of the unreliability of the antineuralgics and analgesics in common use, de Buck and Vanderlinden were led to give Salophen a careful trial in conditions where this class of remedies is indicated. Among 23 cases treated 17 were completely cured, 2 improved, and only 4 not perceptibly relieved. Favorable results were obtained twice in 3 cases of cephalalgia, once in 2 cases of sciatica, in all of 3 cases of odontalgia, in 6 out of 7 cases of facial neuralgia, in 3 of 4 cases of lumbo-abdominal neuralgias, in 1 of 2 cases of intercostal neuralgia, and in 1 of 2 cases of pleurodynia. To obtain prompt effects, however, the remedy must be given in sufficient doses (1 gramme as a single dose, and 3 grammes daily), and this explains the failures experienced by some observers. It is not always necessary to give doses of this size; frequently 0.75 and even 0.5 gramme, repeated once or twice, will suffice to alleviate the pain, if not to effect a complete cure of the neuralgia. This was especially observed in cases of odontalgia, where relief was obtained rapidly from the use of small doses.—*Allg. Med. Central-Ztg.*, No. 1, 1895.

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Selections from Society Proceedings.

DENMARK.

COPENHAGEN MEDICAL SOCIETY.

Thyroiditis Acuta Simplex.—In an exhaustive paper on this subject, DR. HOLGER MYGIND (*Journal of Laryngology*, March, 1895) divides the acute inflammation of the previously-healthy thyroid gland into two varieties, viz., the more frequent *thyroiditis acuta suppurativa*, which terminates with the formation of an abscess; and *thyroiditis acuta simplex*, which terminates in resolution. This latter variety is more rare, Bardeleben declaring that he has never met with a case of it. Dr. Mygind has, however, succeeded in collecting from literature seventeen undoubted cases of acute inflammation of a previously-healthy thyroid gland ending in resolution. To these he adds a case observed by himself.

The disease is most frequently met with in females, in whom, as is known, the thyroid gland is larger than in males. Age seems to play some part in the etiology, most of the cases occurring between the ages of 20 and 40, and especially between 20 and 30. The disease appears to be purely idiopathic, or, at least, without any direct causes of a decided nature. The symptoms develop with great rapidity, there being at first general malaise, fever or rigors, and pain in the front of the neck, of so vague a character that angina or catarrhal fever is often diagnosed. The thyroid gland enlarges during the two days following, reaching the size of a hen's egg, though in some cases it may occupy the whole front of the neck from the inferior maxilla to the sternal incisure, extending on either side to the inner margin of the sterno-cleido-mastoid muscle. When there are redness and distinctly-circumscribed tenderness over the point of enlargement, abscess may be suspected, especially when the gland is elastic or pseudofluctuating.

Spontaneous pains in the swelling are at first severe, but gradually become less so. Decrease in the size of the swelling usually begins on the third day, the other symptoms also disappearing coincidently, often so suddenly as to suggest pneumonia ending in crisis. In most cases no infiltration is left, and only rarely have small, hard lumps been observed. The situation of the thyroid gland is such that when the organ becomes inflamed symptoms arise from the neighboring organs, such as cough, dysphagia, dyspnœa, and hoarseness. Cyanosis, headache, restlessness, etc., may occur from compression of the vessels of the neck. Fever is more or less marked according to the size of the swelling; the pulse and respiration are out of proportion to the degree of fever, owing to the discomfort, pain, insufficient nourishment, and want of sleep.

The etiology of the disease is the most important basis upon which to found a diagnosis; should there appear signs of an acute thyroiditis in the course of diseases which are known to lead to metastatic suppuration, it may be assumed as probable that the inflammation of the thyroid gland will not terminate in resolution, but in the formation of an abscess. Among such diseases puerperal fever is especially noticeable, acute suppurative thyroiditis being particularly frequently caused by that infectious disease. Pyæmia has often been found to be the cause of thyroiditis acuta suppurativa, but never of thyroiditis acuta simplex, whilst typhoid fever may give rise to either form. Rheumatic fever speaks decidedly, and no special cause or a cold, strongly in favor of an eventual inflammation ending in resolution, and not in an abscess. The presence of initial rigors, high temperature, great prominence of a particular part of the gland, also redness, increased temperature, and infiltration of the skin indicate abscess; but thyroiditis may end in resolution, even when all these symptoms are marked, and in some cases it will be possible to diagnose thyroiditis suppurativa only after from seven to twelve days.

The prognosis is always favorable, both as to life and as to the return of the gland to the normal condition. In the treatment, energetic antiphlogistic measures, with ice, leeches, mercury-ointment, etc., prevent suppuration and increase of the swelling to such a degree as to cause suffocation.

FRANCE.

Société de Médecine de Lyon.

Treatment of Tic Douloureux.—M. Grandclément communicated a method of treating this affection from which he claimed excellent results. It consists in making subcutaneous injections of the following solution into the affected side of the face: Distilled water, 10 grammes (2½ fluidrachms); antipyrin, 4 grammes (1 drachm); hydrochlorate of cocaine, 0.03 gramme (½ grain). The face sometimes became much swollen, but soon resumed its normal appearance. One case in which he succeeded was that of a woman of 60 years who had suffered so much that she had decided to submit to resection of the trigeminal nerve. After thirty injections, made within a

period of ten days, over all the painful points, the attacks ceased. A year later they recommenced, though with less severity, and the patient was about to undergo the same treatment when she died from some pulmonary affection. A second patient, who had also decided upon a surgical operation, was submitted to the injections and recovered. A relapse also occurred within one year, but yielded in two days to the same treatment. She had a second relapse in September, 1894, but this was also arrested by the injections in three days. Beyond the complication of œdema, M. Grandclément has seen no ill effects, though he has made use of the solution a great many times.

Tabetic Arthropathy.—PROFESSOR LÉPINE called attention to a peculiar condition which he had observed in two cases of arthropathy in tabetic patients, viz., the occurrence of a swelling some distance from an articulation, at first sight making one think of a cold abscess, but later recognized as simply a collection of synovial fluid. The first case was that of a man who some four months previously had entered his service for the treatment of a fluctuating tumor of considerable size on the outer and middle portion of the thigh, and having all the appearances of a cold abscess. The tumor was incised and, instead of pus, a clear liquid ran out, distinctly resembling synovial fluid. It was then ascertained that the patient was affected with coxo-femoral arthritis, the limb being two centimetres shorter than its fellow, probably from friction of the head of the femur or increase in the size of the cotyloid cavity. The joint was movable in either direction. The patient, who was syphilitic, presented all the signs of tabes dorsalis.

The second patient, also syphilitic and tabetic, had a swelling on the buttock, which on incision gave exit to a clear, filamentous liquid analogous to the synovial fluid. There was an abnormal lax condition of the hip-joint. In both these patients the predominant symptom was the presence of a tumor of the thigh or buttock, the articular lesions being only observed later. As to the origin of these collections, Professor Lépine expressed the opinion that there had been an exaggerated production of synovial fluid, causing rupture of the sac and effusion into the other parts. What is surprising in these two cases is that the fluid was not absorbed.

SOCIÉTÉ DE THÉRAPEUTIQUE.

Forms of Quinine to be Preferred in the Prophylaxis of Malaria.—M. DUJARDIN-BEAUMETZ announced at a previous meeting that the soldiers about to be sent to Madagascar by the French government were to carry with them, for prophylactic purposes, a considerable quantity of quinine, and that it would be desirable to know if one of the salts of that drug were preferable to another, and also which was the most suitable pharmaceutical form for administration. The society appointed a commission to investigate the subject, consisting of MM. ADRIAN, BARDET, BERLIOZ, BOYMOND, and PATEIN. The results of their studies are embodied in the following conclusions: 1. Solutions of quinine salts should be reserved for the attacks of fever. 2. The basic quinine hydrochlorate is to be preferred as a prophy-

lactic measure, as being sufficiently soluble and containing the largest quantity of the alkaloid. It is also less irritating to the digestive passages than the sulphate. The hydrobromate should be employed in rebellious cases of fever in which the sulphate has failed. 3. The compressed preparations should be absolutely rejected, pills made with a soluble excipient, or gelatin capsules, seem to be the preparations of choice in preventive treatment. 4. Two pellets or gelatin capsules containing 0.25 gramme (4 grains) of the hydrochlorate may be given daily, one in the morning and one in the evening, or before the meal, a small quantity of liquid being taken at the same time. This quantity will be sufficient to maintain the organism continually under the influence of the quinine. 5. Whatever pharmaceutical form be adopted, it is indispensable that complete solubility be assured.

SOCIÉTÉ DE MÉDECINE ET DE CHIRURGIE DE BORDEAUX.

Hydatiform Moles.—DR. COURTIN opened a discussion on this subject (*Presse Méd.*, March 13th) apropos of a case observed by him in a woman, 24 years of age, two months pregnant. Expulsion of the tumor occurred without accident, the patient recovering under careful antisepsis of the vagina. He asked if, in such cases, there were not serious danger of infection, and whether intra-uterine curettage should be performed, or whether the case should be left to terminate spontaneously. Those taking part in the discussion were inclined to the latter course.

DR. RIVIÈRE was of the opinion that much depended upon the length of the pregnancy; if it is recent, as two or three months, expulsion occurs spontaneously and there is no need for intervention; when it is more advanced, the mole has penetrated into the serosa of the peritoneum, and myxomatous vesicles have invaded the uterine tissues, so that elimination is not perfect; but even here he preferred to await the appearance of infectious symptoms before curetting.

LUGEOL would curette only when the condition was very grave, as surgical intervention in such cases is in itself a serious matter. When pregnancy is far advanced, the uterus has become thin, the hydatiform vesicles have penetrated the peritoneum, and there is great danger of perforation following the use of the curette; while in cases where the pregnancy is recent, interference is entirely unnecessary.

DR. RIVIÈRE was the more inclined to hold to conservative views from the fact that Chabrely had seen four cases of enormous moles in which the patient recovered without any intervention.

Mercurial Stomatitis.—DR. COURTIN communicated a case of this kind, illustrating the practical importance of searching for the Lœffler bacillus in the mouths of healthy persons or those, at least, not affected with diphtheria. His patient was a young woman who, some days after delivery, showed some slight symptoms of infection, for which it was deemed advisable to make applications of mercurial ointment to the abdomen. These were followed by a mercurial eruption, with stomatitis and pseudomembranous tonsillitis. In order to satisfy himself as to the exact nature of

the throat affection, he arranged to have cultures made, and ordered the patient to use gargles of boric acid, chlorate of potassium, etc., thinking it useless to inject antitoxin. The patient recovered in forty-eight hours, just as a bacteriological diagnosis of diphtheria was sent him. Was it the pseudodiphtheria or the true diphtheria bacillus which was here present? The speaker was unable to say, but what he wished most particularly to point out was that clinical examination must still remain the criterium in certain cases. If injections of the antitoxic serum had been made it would naturally have been regarded, in view of the bacteriological examination, as a case of cure from the use of the serum. He urges that the serum treatment, therefore, be reserved for cases clinically and bacteriologically diagnosed as diphtheria.

SOCIÉTÉ MÉDICALE DES HÔPITAUX, PARIS.

Bad Effects of Chloralose.—M. RENDU stated that he had ordered 0.25 gramme (4 grains) of chloralose for a tuberculous patient, accustomed to hypnotics, who took the dose at midnight. At 2 o'clock he was called upon to see her, finding her in a comatose condition, completely insensible, the pulse 180, the movements of the heart imperceptible, the face and extremities cyanosed, and with epileptoid movements of the limbs. The skin was covered with cold perspiration and death seemed imminent. He gave a first and a second hypodermatic injection of ether, but, the convulsions increasing, he injected 0.0025 gramme ($\frac{1}{25}$ grain) of morphine, and toward 5.30 A.M. the patient began to improve, recovering consciousness at 8.30 A.M. without any knowledge of what had occurred. A slight difficulty of speech persisted for some hours afterward. In commenting on this report, an editorial writer in *la Médecine Moderne*, March 13th, states that five or six similar instances were published in that journal during 1894, in which tetanic, convulsive, or cataleptic symptoms, with amnesia and intellectual disturbance had been observed after the use of chloralose in cachets of from 0.20 to 0.40 gramme (3 to 6 grains). Similar cases have also been reported to the Société de Thérapeutique. The frequency of these symptoms is somewhat difficult to determine. A Russian physician, Chemelewski, observed them in two out of seventeen cases of insanity in which he made use of the drug. On account of the intellectual disturbance, the loss of memory, sometimes lasting several hours, and the fear experienced by the family of the patient on the appearance of such symptoms, it would be wise to restrict the use of chloralose, and to advise the patient, or, at least, the attendants, of the possibility of nervous symptoms supervening upon its use.

Trional.—M. L. GALLIARD prescribed this hypnotic to forty patients, giving a uniform dose of 1 gramme (15½ grains) daily in unleavened bread to avoid the disagreeable taste of the drug, which is soluble only in a large quantity of hot water. In one case he administered it in a rectal injection. Five of the patients showed themselves refractory to its influence, but in the other thirty-five it was at least partially successful. Sleep was obtained in

twenty or twenty-five minutes and lasted almost all night. He observed no accidents; in some cases there was nightmare, or vertigo, slight headache, or nausea on awakening. There was no circulatory, gastro-intestinal, respiratory, nor urinary disturbance. He had not observed hæmatoporphyrinuria, although none of his patients had taken more than six consecutive doses. M. Raymond had analyzed the urine of a patient who had taken daily doses of 1.50 grammes (24 grains) of trional for a period of five weeks, and had found red globules, a small quantity of globulin, no sugar, but a reducing body deviating to the left 0.4 to 0.5 degree (*lævogyre*). M. Galliard considered trional especially indicated in neurasthenic cases, on account of its having no other action than a purely hypnotic one.

Effect of Subcutaneous Injections on Tuberculous Children.—M. Hutinel gave the results of his researches in this direction, his first experiments having been made with tuberculin. A daily dose of $\frac{1}{20}$ to $\frac{2}{10}$ or $\frac{3}{10}$ milligramme always caused more or less intense symptoms of reaction. The same symptoms were observed after the use of other agents, Hayem's serum (H_2O and NaCl 7 to 1000) causing an almost identical febrile reaction, which was also noted in children free from tuberculosis, though it was not quite so marked. Solutions of deuteralbumose and peptone gave the same results, as did also animal serum. In making subcutaneous injection of antitoxic serum, therefore, the fact should be borne in mind that they may cause fever in healthy children, but that the reaction may be much greater in tuberculous children, in whom they may determine active congestion in tuberculous areas.

M. Legendre had observed no such reaction in the case of a child with coxalgia whom he treated for diphtheria with injections of the serum.

M. Sevestre believed that the injection of the serum might favor the development of the tuberculous disease, and he questioned whether it would not be wisest to treat cases of diphtheria occurring in such children by means of the older methods, reserving the antitoxin for very grave cases.

Académie de Médecine, Paris.

Alcoholism in France.—Dr. Lancereaux stated that the increasing use of alcoholic drinks among the Parisian population is a state of things that renders it incumbent on every one not only to attempt to check the evil, but to seek for a remedy. (*British Medical Journal*, March 16, 1895.) He eloquently condemns the practice of taking *amers* and *apéritifs*, which are dangerous essences. During a period of several years he has observed, among his hospital patients, a constant increase of cases of chronic absinthism, whilst alcoholism remained stationary. He applied to the Director of the *Contributions directes*, who furnished him with statistics showing that the consumption of absinthe and similar beverages increases yearly to an alarming extent. It appears that, among 20 patients admitted into hospital wards receiving such diseases as those treated in Dr. Lancereaux's wards, there are 10 of cases resulting from an abuse of alcoholic drinks,—5

from wine and 5 from absinthe and similar beverages. He proposes that the number of *cabarets* (small taverns) should be reduced; that the tax on cider and beer should be as low as possible without the quality of these drinks suffering from the reduction; that the use of wine should be popularized as much as possible, and that only pure wine should be sold; that the tax on potable alcohol should be increased; that the sale of beverages known as *amers* and *apéritifs* should be prohibited, as the essential oils they contain have a most pernicious effect on the public health.

GERMANY.

Gesellschaft fur Psychiatrie.

Biernacki's Ulnar Symptom in Paralysis.—Herren Baedeker and Falkenberg read a short communication connected with an inquiry as to whether this symptom was present in paralytics as frequently as stated, and whether it was very infrequent in non-paralytics and tobacco-smokers. (*Medical Press and Circular*, March 13, 1895.) When the ulnar nerve is pressed with sufficient force at the elbow, three sorts of reaction take place: a purely motor, of flexion of the phalanges supplied by it, with extension; abduction or adduction of the thumb; a purely sensory, with tingling, burning, and smarting; and, under some circumstances, withdrawal of the arm, painful contraction of the face, with accompanying interjections. This last reaction has been called by the unfortunate name of reflex, as if it were similar to the patellar reflex; whereas it was nothing more than an exceedingly changeable motor symptom, which would be much better described as a defensive movement against pain. There was no specific reaction, but the unpleasant sensation of burning, tingling, etc., caused such pain that numerous protective movements were made. It was best, therefore, to avoid the expression reflex, and to employ instead that of "pain-reaction." The whole pain-reaction passed away so rapidly that it required the closest attention to determine it. There were cases in which it was present on a first trial and absent at another time. One hundred and twenty male and 25 female paralytics were tested at various stages of disease. On repeated trial it was ascertained that, of 100 men, the pain-reaction was absent in 58, present in 35, in a typical manner in 28, and developed in 7. The results were practically identical in the 25 women; in 56 per cent. there was no pain-reaction, in 36 per cent. there was reaction, and in 8 it was doubtful. As a control inquiry 200 male and 100 female non-paralytic insane were next examined. In the 200 men the pain-reaction was distinctly present in 51 cases; in 139 it was absent. In 100 women it was evident in 67 per cent. and absent in 33. Under these conditions it would be useless to look upon the sign as an aid to differential diagnosis. The speakers formulate their conclusions as follows: I. Analgesia of the ulnar nerve is not a typical symptom and is of no value from a differential-diagnosis point of view. II. Analgesia of the ulnar nerve is apparently tolerably frequent in disease of the posterior columns.

GREAT BRITAIN.

LONDON PATHOLOGICAL SOCIETY.

The Pathology of Pneumonia.—Fact and hypothesis were happily blended in the communications made by DR. WASHBOURN and DR. WRIGHT on the pathology of acute lobar pneumonia (*Lancet*, February 16, 1895). Dr. Washbourn rigidly confined himself to observations upon the microbe that has been proved to be the almost constant concomitant of this disease; whilst Dr. Wright, in his suggestive reasonings from analogy, put forward sundry explanations of the remarkable phenomena that characterize it. The bacteriological history of acute pneumonia is instructive, since in the first instance the bacillus discovered by Friedländer was thought to be—and the view received support from many sides—the pathogenic organism responsible for exciting it; but Dr. Washbourn's statement that the real "pneumococcus" is that discovered by Fraenkel and Talamon, and studied by Sternberg and Weichselbaum and many others, is in accord with general opinion. Dr. Washbourn pointed out that the occurrence of the pneumococcus in healthy secretions did not militate against its pathogenic property, instancing diphtheria as an example of this. Now, although a practically similar conclusion was arrived at some years ago by Dr. Sternberg, it must be admitted that the fact enlarges the view of the microbic origin of disease. It seems to demand the intervention of a second factor, disposing the body to the action of the organisms. Indeed, for pneumonia such a factor has been assumed in the phrase "lowered vital resistance," such as may be produced by cold or exhaustion, rendering the subject more vulnerable. Experimentation upon animals with regard to the pneumococcus has brought out many interesting facts as proving its relation to inflammatory processes in various tissues and organs; but it cannot fail to strike the clinical observer that the parts mostly attacked by inflammation after "pneumococcal" inoculation are not those which are prone to such lesion in the human disease. This was partly explained by Dr. Wright's statement that the pneumococcus had mainly a local action, and that in acute pneumonia its entrance is obviously by the respiratory tract.

The question of immunity and the allied subject of the use of "curative serum" has been studied experimentally in pneumococcous infection for some time, notably by Drs. G. and F. Klemperer, of Munich; indeed, some of the earliest work on "antitoxins" was that done on the occasion in question by these observers. It is clear, however, that more requires to be proved before the practical application of such researches can be adopted. Moreover, in a self-limited disease like pneumonia it will be assuredly a difficult matter to determine whether the abatement of symptoms is due to the administration of serum from an immunized subject—*e.g.*, the blister serum from one who has just passed through an attack—or to the natural termination of the process. Amongst the striking phenomena of this remarkable disease must be reckoned the occurrence of crisis and the reabsorption of the mass of exuded leucocytes, which convert the spongy tissue into a solid gray mass. Dr. Wright advanced an interesting explana-

tion of the crisis when he compared it with the phenomena of spirillum fever. Crisis is denoted by a rapid fall in the excessive leucocytosis that precedes it, and this means the withdrawal of pneumococci from the blood: yet neither the height of the fever nor the degree of crisis is influenced by the amount of lung involved,—*i.e.*, of leucocytal emigration from the blood; nor do signs of resolution concur with those striking changes in the functions of the whole body which supervene at the crisis; nor, finally, as Dr. Washbourn says, do the pneumococci exist to any marked extent in the blood. That the re-absorption—sometimes with great rapidity—of the large amount of nucleo-albumin, of which exuded leucocytes are composed, does not lead to intra-vascular thrombosis, in accordance with the late Dr. Wooldridge's beautiful demonstration, is remarkable and was explained by Dr. Wright by assuming an equally-rapid elimination by the urine—and in some cases, perhaps, by the bowels—of the absorbed material. It is well known, however, that the periods of crisis and that of commencing resolution are often those at which the need for free stimulation is most urgent; and it is a question whether some of the deaths at this period of the disease attributed to cardiac failure may not really be due to cardiac thrombosis. In either case alcohol is indicated, and, it may be added, ammonia, another time-honored remedy, would equally answer the indications; and most physicians would rather trust to it than to citric acid to prevent the tendency to coagulation within the blood-vessels.

Ophthalmological Society of London.

Diphtheritic Conjunctivitis Treated by Antitoxin.—Dr. W. H. Jessop (*Lancet*, February 9, 1895) described two cases, the first of which was that of a boy, aged 19 months, who had membrane on the upper and lower palpebral conjunctiva of the left eye, and a patch of membrane on the left side of the uvula; one lymphatic gland over the parotid was enlarged, and there was albumin in the urine. Three injections of Klein's antitoxin were given, 1½ drachms (6 cubic centimetres) in all; the membrane disappeared in five days, and was not followed by conjunctivitis nor other conjunctival change. There was no local treatment except distilled water. The second case was that of a male child 8 months old. There was membrane on the palpebral conjunctiva of both eyes; the parotid lymphatic glands were enlarged; there was a mucopurulent discharge from the nose. Two injections of Klein's antitoxin, 1 drachm (4 cubic centimetres) in all, were given, but there was no local treatment. The membrane disappeared in four days.

Dr. Hayward had examined the membrane in both cases and found large quantities of Lœffler's bacillus. The membrane was well marked and only affected the palpebral conjunctiva.

Myopia.—Mr. C. Wray read a paper on removal of the lens in high myopia, with a case of —25 D. The operation was not applicable in the case of children with less than 10 D. nor in adults with less than 12 D. of myopia. The objects of the operation were: (*a*) to prevent detached retina; (*b*) to arrest or prevent retino-choroidal changes; and (*c*) to enable patients

with the highest grades of myopia to work at reading distance if unable to do so. He presented statistics of myopia of 123 patients; 38 cases, including 3 cases of detached retina, had vision less than $\frac{6}{36}$ in one eye, whilst 10 had vision less than $\frac{6}{36}$ in both eyes. His figures admitted of three deductions: that the vision was invariably less in the fourth decade than in the third; that retinal detachment was less to be feared than the changes in the retina and choroid; and that it was not necessary to regard every myope of 12 D. and upward as hopelessly drifting toward detached retina and blindness. He had seen a case of retinal detachment after the removal of a lens in a case of myopia of 30 D., and considered detachment comparatively frequent after operation. He pointed out that in myopia of low degree, associated with zonular cataract, the crescent is at times out of all proportion to the amount of myopia; on the presumption that this was due to amblyopia, it was a common thing to remove zonulars when the patient could see $\frac{6}{24}$ and J. 4, but, unfortunately, hospital reports did not furnish the subsequent history of these cases. As regarded the prevention of changes in the choroid and retina, the only case that would appear to bear upon the point was Meyer's, in which, after the removal of a lamellar cataract from a myope, the fundus changes were said to have progressed, and, judging from the statistics at the speaker's disposal, more rapidly than they would have done in all probability in the natural course of events. The point on which there was unanimity was that the patients were able to work much better after the operation, and that some were enabled to follow vocations which had previously been impossible.

Mr. Spencer Watson said he would hesitate to undertake the operation, not seeing how removal of the lens could relieve the progressive changes in high myopia. He had once removed a lens with its capsule for cataract in the subject of a high degree of myopia, and there had been some loss of vitreous, but the patient recovered well and with improved vision.

Mr. Marshall, Mr. Hodges, Dr. Rockliffe, and Mr. Ridley mentioned cases in which interference had proved unavailing.

Mr. Doyne did not think that loss of the lens would improve vision in a myopic and amblyopic eye.

Mr. Lang had operated for black cataract in an eye with 23 D. myopia. Vision was improved from $\frac{6}{36}$ to $\frac{6}{12}$, but after some months the retina became detached. The same thing occurred in the other eye; so that he did not think it could be attributed to the operation. On the whole, his experience was not favorable.

Mr. Wray said that the age at which the operation was performed was of great importance. Cases showing 10 D. myopia between the second and fourth decades underwent marked deterioration later. All those alluded to in the paper were amblyopic eyes with crescents. He thought the longer it was postponed the worse it would be. The operation would involve removing immature cataracts at the most dangerous age, and speakers had not mentioned the ages of their unsatisfactory cases.

UNITED STATES.

New York Academy of Medicine.

Perforations of the Nasal Septum.—Dr. A. Rupp stated that the causes of perforation of the nasal septum might be considered conveniently under five heads, as follow: (1) congenital or developmental influences; (2) traumatisms; (3) contiguous pathological processes; (4) diseases engendering such constitutional and local conditions as are common to syphilis, tuberculosis, lupus, scrofula, rheumatism, diphtheria, fevers, etc.; (5) local inflammatory and allied processes. Congenital or developmental perforations are extremely rare; according to certain authorities, they are of two kinds: (*a*) those due to perverse or arrested development; (*b*) those due to a pathological process implanted on the developing tissues. Traumatisms have been known to give rise to perforations of the septum, and such a case had recently come under his own observation. Among the contiguous phenomena which may give rise to perforation may be mentioned rhinoliths and polypi. As to constitutional influences, it is only rarely that scrofula, tuberculosis, and lupus cause a septal perforation, but that they may do so cannot be denied. Syphilis is a much more potent factor in the production of this lesion. Chiari, in his group of 77 cases of ulcers, cicatrices, and defects of the intra-nasal parts, found 62 of these lesions caused by syphilis, 5 by lupus, 4 by scrofula, 1 by blennorrhœa, 1 by tuberculosis, 1 by diphtheria, and 2 by undetermined causes. These figures illustrate approximately the frequency of syphilis as a probable cause of septal perforations. Like tuberculosis, lupus, and scrofula, syphilis favors the septum—especially the cartilaginous portion—in its attacks. Rheumatism, as well as typhoid fever, and even metastatic carcinoma, have caused septal perforation, but in rare instances. According to some authorities, chronic coryza may lead to perforation; also acute perichondritis and abscess of the cartilaginous portion of the septum. Many authors have also reported cases of simple perforating ulcer of the septum.

These lesions can be treated successfully only by doing away with the pathological influences that give rise to them, and by attempting to obtain the most favorable conditions, by means of general and local remedies, for aiding the recuperative forces of the local tissues to cover the losses they have sustained. Curetting, the galvano-cautery, and the application of various drugs, such as the acid nitrate of mercury, yellow oxide of mercury, nitrate of silver, etc., have been employed with more or less success. Whatever is done in this way, care should be taken not to destroy nor irritate too much the healthy tissues from which reparation proceeds.

Extensive Perforations of the Bony Septum.—Dr. Delavan stated that perforations of the nasal septum, situated near the posterior edge of the cartilage of the septum, and of not too great a size, are seldom of any serious pathological importance. There is a class of perforations, however, which is deserving of more attention than has heretofore been given to it, namely, the more or less extensive injuries sometimes produced in the course of operations on the septum, and involving a loss of substance in the vomer.

Such an accident is apt to occur during the attempted removal, by means of the saw, of what appears to be a septal ridge, but what in reality is a sharp horizontal deflection of an unusually thin septum. Instead of a ridge being removed, a long, narrow opening, parallel with the floor of the nose, is made between the two nasal cavities. In several cases coming under the author's observation, in which this accident occurred, the patient suffered marked symptoms of general shock, quite out of proportion to the apparent importance of the injuries inflicted. In one case particularly the reflex phenomena were very pronounced. Within twenty-four hours after the operation there was marked mydriasis of the right eye, followed later by complete paralysis of the accommodation of that eye. Several months elapsed before the eye resumed its normal condition, although the patient meanwhile was under the care of an accomplished ophthalmologist. In another case the patient suffered unduly from shock, and believed himself to have been distinctly injured by the operation. Theoretically, there is very little of anatomical importance in this part of the septum, excepting the nerve-supply. The latter, however, is important, and the fact remains that, in the writer's experience, injury to it is sometimes followed by severe disturbance.—*Journal of Laryngology*, February, 1895.

New York Obstetrical Society.

Repair of Uterine Injury Immediately After Labor.—Prof. A. P. Dudley gave the result of his experience with the immediate repair of injuries after delivery, expressing the opinion (*American Journal of Obstetrics*, February, 1895) that the dangers attending manipulation of the genital tract and the immediate repair of all injuries discoverable are of less risk to the woman, not only from an increase of any shock she may have sustained during delivery, but from post-partum hæmorrhage or puerperal infection, and far less dangerous than those to which she may be subjected in the future as a result of the accoucheur's ignorance or negligence to perform such a service for her immediately after her child is delivered. He has performed immediate repair in 21 cases since 1889, and has yet to see the first bad result from such manipulation. He almost invariably administers a small quantity of chloroform during the third stage of labor, and, as a consequence, while waiting for the placenta to be delivered the patient usually sleeps. During this time he examines the perineum, urethra, and vestibule, to see if any injury has occurred. As the placenta is delivered, the patient being in the Sims position, he keeps her there, with the nurse making pressure on the fundus, until he can thoroughly wash and disinfect his hands, when he gently introduces one or two fingers into the vagina, and, knowing that in the majority of cases the uterus gives way bilaterally, he passes them to the right and left of the cervix, to discover if laceration has taken place. The relatives of the woman are informed that such laceration exists; some one of the family is called to continue a few drops of the chloroform; a large Sims speculum is introduced and held in place by the nurse, even if the perineum is torn down to the sphincter. The operator then removes any

shreds of membrane still clinging to the cervix, after thoroughly washing the vagina with a solution of bichloride of mercury (1 to 5000), and brings into apposition each lip of the cervix (the anterior and posterior halves) with a small pair of forceps, the tear being then readily made evident. He introduces a pledget of sterilized gauze or cotton, saturated with a solution of bichloride of mercury, into the cervix beyond the point of rupture, and with an Emmet cervix-needle—curved, trocar-pointed, and with a large eye, armed with No. 5 catgut—makes as many sutures as are necessary. This can be easily done, as the tissues are so flabby and soft. The stitches are inserted after the manner of Dr. Emmet, but none are tied until all are introduced. He then removes the cotton or gauze pledget, cleanses the cervix and vagina with a fresh bichloride solution, and ties the sutures with enough traction upon them to insure coaptation of the parts as the cervix contracts.

From his personal experience Professor Dudley presented the following conclusions: 1. That suturing the lacerated cervix properly, immediately after delivery, will result in primary union of the same and prevent many of the evils that follow in the wake of a union by second intention. 2. That the fear of septicæmia attending the manipulation of the cervix, and the introduction of poisons which will induce septicæmia at the same time, is an unfounded one, and would be dissipated by giving such work a proper test. 3. That it is a method of procedure more justifiable than an immediate repair of the perineum, which the profession of to-day universally advocates. 4. That the securing of primary restoration of the laceration hastens involution, prevents subinvolution and the various forms of displacement which are induced by it in such an overweighted organ. 5. That catgut is the proper suture and perfectly safe and reliable when carefully prepared.

Dr. C. C. Barrows regarded immediate repair as indicated (1) to stop hæmorrhage; (2) to cut off an avenue for the introduction of sepsis; (3) to prevent subsequent troubles; (4) to favor uterine contraction. Lacerations high enough to cause considerable bleeding were apt to be followed by relaxation of the uterus. The only restriction he would place upon the immediate operation was in the case of multiple tears, with little tissue between, when the number of sutures required might cause constriction and sloughing.

Dr. Charles Jewett did not think that fatal septicæmia often resulted from cervical lacerations, generally springing from the cavity of the uterus. An experienced obstetrician might perform the immediate operation in tears of considerable depth, but more harm than good might result if every practitioner were to undertake it. Personally, he preferred the dorsal position, as the uterus could thus be easily crowded down and the cervix reached even without a speculum.

Dr. W. T. Lusk had for years always made immediate repair where it was possible to get the permission of the family. It was well to be prepared to perform it in cases of placenta prævia, as the cervix was friable and likely to be ruptured and give rise to profuse hæmorrhage, which could be controlled at once by a few sutures.

Dr. R. A. Murray supposed that most members of the society would resort to repair of the cervix after labor if there were hæmorrhage; all men of experience were now agreed that it was the best method of arresting hæmorrhage, but the general profession and medical students had yet to be impressed with the fact. He was of the opinion that the operation should be repaired even when hæmorrhage was not an indication, provided the laceration was greater than could be reduced by retraction of the uterus. As to multiple lesions, he thought that these were more apparent than real, depending upon outward reflexions of the mucous membrane just after extrusion of the child. Later they would be found retracted within the canal.

Medical Society of the State of New York.

Prognosis and Treatment of Psoriasis.—Dr. L. Duncan Bulkley based this paper on three hundred and sixty-six cases of psoriasis seen in private practice. The disease occurred a little oftener in males than in females, at all ages, chiefly from 15 to 30 years of age. It was essentially chronic, in the cases mentioned having existed five to ten years before the patients consulted him. In one instance it had existed thirty years. The point emphasized was that psoriasis was not a local disease, but depended upon a general condition which produced the eruption again and again. It was closely associated with gout and faulty metabolism. It was benefited by alkaline remedies, counteracting acidity of the blood and urine. Local treatment was only of secondary importance. Psoriasis could and should be cured, just as gout, chronic bronchitis, etc., could be cured.

Treatment of Eczema Capitis by Salicylate of Soda.—Dr. C. E. Lockwood, of New York, related a case of eczema of the scalp in a man of rheumatic tendency, the rheumatism disappearing with the appearance of the eruption. This had continued four years when he saw the patient and instituted treatment, which included the administration of salicylic acid. The scalp-eruption thereupon disappeared. He hoped others would try salicylic acid in cases of eczema in patients with rheumatic history. Dr. Haig, of London, had expressed great interest in the case and had written that he would certainly try the salicylic-acid treatment in future in rheumatic cases of eczema.

Dr. L. D. Bulkley agreed with Dr. Lockwood as to the necessity of treating the patient's general condition rather than the local eruption in certain skin diseases. He had used salicylic acid for years in eczema in cases of rheumatic diathesis, and had written upon it and the use of water as a diluent, and the necessity for eating sparingly of meats, many years ago.

Dr. Elsner said that in rheumatism and so-called uric-acid diathesis the trouble was not due to excess, but to retention, of uric acid. He did not approve of cutting off all meat diet. The point was to see that metabolism went on perfectly, and, where it did not, the trouble might lie in a cup of coffee, or other like things, instead of in meat and foods which were wholesome for most people.

DR. WILLIAM MADDREN, of Brooklyn, called attention to the preventive value of water for washing out the system.

DR. BULKLEY did not entirely forbid meat in all cases, but he had found an excess of meat diet to be at fault in many instances.

Malarial Origin of Zoster.—DR. JAMES MACFARLAND WINFIELD, of Brooklyn, showed by quotations, in the first part of this paper, that the etiology of zoster was not at all settled. A nervous influence had often been remarked upon, but the direct cause of the nervous and eruptive phenomena had remained unknown. The occurrence of the disease in patients living in malarial districts had led him to examine the blood for the malarial parasite in seven cases coming under his observation. In three there was unmistakable evidence of malarial poisoning, as demonstrated by the plasmodium malariæ. In another this test had been rendered nugatory by the previous administration of quinine. In some of the others it was probable that the malarial parasite would have been shown had proper examination been made. With this evidence the author thought it could be asserted that malaria might, and did, produce herpes zoster.

DR. H. J. MORTON, of Brooklyn, said that the occurrence of pain along the nerve, preceding the eruption, showed that the nerve was primarily affected. But what was the exciting cause of this inflammation around the nerve? It seemed highly probable that it was a toxic influence in the blood itself. It was known that the poisons of alcohol, syphilis, malaria, etc., often attacked the peripheral nerves. The persistent neuralgias of malarial origin indicated a tendency for the malarial poison to affect particular nerves, and the evidence given in the paper made it probable that the eruption of zoster was due to the same cause.—*Medical Record*, March 9, 1895.

Selections from Reports of Members of the Annual's Staff of Correspondents.

Denmark.

DR. F. LEVISON,

REFERENT FOR DEN DANSK LITTERATUR VEDRØRENDE: ALMINDELIG MEDICINSK PATHOLOGI OG THERAPI, DERI INDBEFATTET, NERVE- OG SINDSSYGDOMME, PÆDIATRIK, OBSTETRIK, GYNÆKOLOGI, HYGIEINE, DEMOGRAPHI, RETSMEDICIN, PATHOLOGISK, ANATOMI, BAKTERIOLOGI.

Alle medicinske Böger, Disputatser, Monographier, Tidsskrifter, etc., der adkomme i Danmark bedes sendt til

DR. LEVISON,
Norrevoldgade, 13,
Köbenhavn.

Aphasia Following Pneumonia.—ISAGER (*Hospitals-Tidende*, R. 4, B. 2, p. 1042) observed aphasia, in a boy 9 years old, consequent upon an attack of pneumonia, which had ended with crisis. The aphasia was complete, the boy being unable to speak, to repeat words addressed to him or to read, but he could understand and execute orders such as to stand up, show his tongue, etc. After a fortnight the aphasia gradually disappeared.

Paralysis of the Heart.—FLÖGSTRUP mentions a case of sudden death from paralysis of the heart. (*Ugeskrift for Läger.*) The patient, a woman 34 years of age, was suddenly taken ill and died in half an hour. At the necropsy there were found a moderate

degree of arterio-sclerosis of the aorta, stenosis of the entrance to the coronary artery, and fatty degeneration of the heart.

Subcutaneous Emphysema in Labor.—A. ULRIK describes a case of subcutaneous emphysema in a healthy primipara 28 years of age. (*Ugeskrift for Läger*, p. 121, 1895.) The woman had been in labor ten hours and one child was already born, when, the pains having recommenced, the midwife advised the patient to make a strong effort to complete the delivery. Suddenly the face and neck of the woman became swollen and the pains ceased completely. A surgeon was sent for and delivered a second child with the forceps. The face of the patient was then so swollen that the eyes could hardly be opened, the swelling reaching to the hair and downward over the neck to the breast and back, ending at the angle of the scapula. A marked crepitation was everywhere felt by the finger, thus rendering positive the diagnosis of subcutaneous emphysema. The voice was hoarse and there were pain and difficulty in swallowing, but nothing abnormal could be detected in the lungs. The explanation of the condition was probably that the tissue of the lungs had given way in the vicinity of the hilus, and the air had made its way from there to the neck and head. The patient recovered completely in fourteen days.

Hypertrophic Biliary Cirrhosis.—FABER observed the case of a man, 41 years of age, who, after cleaning a foul drain, was attacked with hypertrophic cirrhosis of the liver. (*Hospitals-Tidende*, p. 1027, 1894.) The symptoms were fever of the remittent type, loss of force, and pain in the right hypochondriac region. The liver was enlarged and reached five or six centimetres below the costal curvature. After some time the motions became fetid and clayey. The temperature rose during the attacks of fever to 40° C. (104° F.), and fell during the remission to 36° C. (96.8° F.), and once even to 34.9° C. (94.8° F.). Coma ensued, followed by death. At the autopsy the liver, which weighed 2000 grammes (64 ounces), showed a large new growth of connective tissue and round cells in the vicinity of the portal vein and the gall-channels, while the central veins were quite normal. The cells of the liver were healthy, without fatty degeneration. No micro-organism could be detected in the bile.

The same author reports another case, in a woman 27 years of age, in which the pain and fever were supposed to be caused by gall-stones and treated by cholecystotomy. The gall-bladder contained no secretions, but, after some days, when the bile commenced to flow out of the wound, the fever diminished gradually and the patient recovered. In the bile obtained, with all necessary precaution before the operation, a bacillus was found resembling, in many respects, the bacterium coli commune, but which did not coagulate milk.

Habitual Abortion.—*Asafœtida* in 1½-grain (0.1 gramme) pills, beginning with two and gradually increasing to ten daily, then reducing gradually. Five cases thus treated successfully, with no unpleasant symptoms. (WARMAN, *Therapeutische Monatshefte*, January, 1895.)

Russia.

DR. J. DRZEWIECKI,

Редактор-Корреспондент из области русской литературы, касающейся: Общей медицины и терапіи, педіатріи, акушерства, гинекологіи, ларингологіи, отологіи, гигіены, демографіи, судебной медицины, гистологіи, бактеріологіи, анатоміи и физіологіи.

Всѣ періодическія, медицинскія изданія, сочиненія, стат'и, монографіи и т д., изданныя на русском языкѣ и касающіяся вышепоименованных предметовъ должны быт' адресованы на имя

Дра Дрзевецкаго.

87 Краковское Предмѣст'е,

Варшава.

The Influence of Grape-Sugar on Healthy Persons.—DRS. VERESTCHAGIN and NOSENKO (*Vratch*, No. 45, 1894) undertook a series of experiments on this subject in the clinic of Professor Chudnowsky, at St. Petersburg, giving 70 grammes (2¼ ounces) of grape-sugar daily to a number of persons, and arriving at the following conclusions: 1. Assimilation of nitrogen and the fat of foods is increased. 2. Metabolism of nitrogen diminished. 3. Not only was no diuretic action observed, but, on the contrary, the quantity of urine diminished. 4. The quantity of deficiently-oxidated products in the urine diminished. 5. The quantity of ethereal sulphuric acid also diminished. 6. The quantity of excrement increased and the percentage of water in it also augmented. 7. The losses through the skin and lungs increased. 8. Notwithstanding these facts, the excretion of water from the body was slightly retarded. 9. Nothing positive could be determined as to the action of grape-sugar on the body-weight.

The majority of those experimented on felt some fullness in the pit of the stomach and a sense of satiety. No distinct flatulence occurred. Two persons suffered from great thirst, and in two others the quantity of excrement doubled, but without diarrhœa, evacuations occurring twice daily without pain. No sugar was found in either the urine or fæces.

Rectal Examination of Pregnant Women.—W. H. BECKMAN (*Shurnal akuocherstwa i Shenskich bolesnej*, September, 1894) has tried this method with great success in 100 parturient women, the details of pelvis and cervix being easily made out. The length of the pregnancy and state of the bladder could not be determined in 7 per cent. of the cases, and the fontanelles and sutures could not be felt in 28 per cent., but this was less important, since the position of the fœtus could easily be detected by external examination and especially by auscultation. It was always possible to distinguish the occipital from the frontal portion of the head. The advantage of rectal examination is that infection through the genitals is avoided, the only objection being that sometimes examination through the vagina may become necessary, and that infection may occur through the examining finger, though the latter is easily disinfected, since the rectum does not contain specific microbes. The author considers rectal examination of great value to midwives, enabling them to determine if the presence of an obstetrician will be necessary. Zweifel's experience in the Leipzig obstetrical clinic showed that students instructed in this method of examination could determine all the necessary details without recourse to vaginal examination. Ries believes that midwives should be forbidden to make examinations through the vagina, as their duty is only to assist at normal births. Krönig

is inclined to permit vaginal examinations only (1) when it is difficult to determine through the rectum what part of the fœtus is presenting, (2) when the midwife is not able to bring about relaxation of the cervix, and (3) when the pains last more than two hours.

Viburnum Prunifolium in Abortion.—MME. MICHAILOWA (*Meditzinskoje Obozrenije*), after a trial in four cases, states that, contrary to the accepted opinion, this remedy not only does not always prevent abortion, but sometimes even occasions it or, at least, accelerates a miscarriage already commenced. The hæmostatic action of the drug (2 grains—0.13 gramme—in powders four times daily) was constantly observed, but in two cases, after the first day, contraction of the uterus followed, favoring the commenced abortion. In three cases, directly after the administration of a dose, contraction of the external os was observed. The author believes that, although viburnum may occupy a prominent place in the treatment of female diseases, it is not without danger in cases of threatened abortion.

Therapeutic Value of Ephedra Vulgaris.—VESTENRIKA (*Vratch*, No. 6, 1895), at the suggestion of Professor Chudnowsky, of St. Petersburg, studied the therapeutic value of this drug in the Cronstadt Maritime Hospital and the Alexander Hospital. He administered it either in decoction or infusion, and ascertained that it had some sudorific, but no great diuretic, action. In small doses it increased the peristaltic movements of the bowels. As an antirheumatic it was of doubtful efficacy; at least, in the cold climate of Russia; and as a cardiac remedy it was entirely without value.

Influence of Pneumothorax on the Course and Termination of Tuberculosis of the Lungs.—B. NOSCHNIKOFF states, in the *South Russian Medical Gazette*, Nos. 31, 32, 1894, that he had under observation during a long period eight phthisical cases complicated by pneumothorax, four of them ending fatally, the pneumothorax having exercised a pernicious effect on the course of the tuberculosis; the other four cases improved during the progress of the complicating disease. No accurate prognosis could be given in any of these cases. One patient, after the formation of a pneumothorax, with considerable changes in both lungs and in an almost hopeless condition, improved; while another, with changes only in one lung and in good general health, grew worse when the pneumothorax appeared, and died. In four cases of pneumothorax with fatal ending the exudation was putrid; in cases, however, where its influence on the course of tuberculosis was favorable, the exudation was serous. The mechanical action (pressure) of pneumothorax with serous exudation upon the affected lung, causing a lesser supply of blood to the diseased foci, retarded the whole process in the lung, diminishing the quantity of sputum and lowering the temperature. A longer duration of such a condition might induce healing of the tubercular foci. Pneumothorax with putrid exudation produces such a bad effect on the general health that the local pressure cannot be taken into consideration as exercising any counteracting effect. These cases indicate that when severe exudation is present puncture should only be made when the exudation threatens life. Although the indications are distinct for the surgical

treatment of putrid exudation, the author does not believe that much good may be expected from it.

Sweden.

DR. F. EKLUND,
Brefväxlande Medarbetare
för den
SVENSK MEDICINSK
LITTERATUR.

Af alla i Sverge utkommande medicinska tidskrifter, bocker, afhandligar, monographier a. s. v. torde ett exemplar benäget öfversändas till

DR. ABRAHAM
FREDRIK EKLUND,
Sibyllegatan, 3 A,
Stockholm.

Termination of the Dental Nerves.—GUSTAF RETZIUS has studied the course and termination of the dental nerves in the brown rat, these studies being supplementary to previous researches on the same subject in the reptile. He was able to confirm (*Svensk. lak. förhandl.*, October 23, 1894) his previous observation that the delicate varicose ends of the nerve-filaments push their way out through the odontoblastic stratum, spreading over its cells and sending ramifications through it immediately beneath the dentine. He could not find that they penetrated into the dentine canals, nor that there were any special terminal filaments. The sensibility of the dentine might be accounted for by the hypothesis that irritation is conducted through the ramifications of the odontoblastic protoplasm in the dentine to the extremities of the nerve-filaments over the odontoblasts.

A Rare Form of Acne.—In a paper read before the Swedish Society of Physicians, MAGNUS MULLER described the case of a widow, aged 53 years, in whom ulcerations of the nose appeared, crusts forming in the nostrils and spreading rapidly outward in the shape of large, yellow, and painful spots. Within three months the disease had covered the lower half of the nose and the upper half of the lip. The skin on the nose was reddened, thin, and glossy in some parts, and showing rough spots, as large as a pea, in others. When treatment was neglected, waxy or brownish-gray crusts appeared, which, on removal, showed the thin, slightly-moist epidermis, and in other places superficial excoriations or deep, sharp-edged ulcerations from which a yellowish-gray pus exuded. The whole appearance was that of exceedingly-vascular infiltration of an indolent nature, the principal seat of which was in the follicles of the skin. The ulcerations healed rather slowly, independent of any treatment, new ones appearing in the vicinity, healing in their turn and leaving superficial scars. Foci about as large as a bean, and similar in appearance to those on the nose, also developed on the left cheek, the chin, and behind the left ear.

Subcutaneous Injections of Antipyrin.—BERGQUIST has used antipyrin subcutaneously with excellent results (*Eira*, xix, No. 3, p. 73), employing a watery solution, injecting 1 gramme (15½ minims), and rarely 2 grammes (31 minims), each time, following with massage at the point of injection. The pain, which is excruciating, lasts about half a minute. Of 130 cases of lumbago thus treated, 122 were cured. In 8 out of 18 cases of ischias, the results were very satisfactory, as they also were in all the cases of hemicrania, though here the pain of the injection was so intense that many of

the patients did not return for a second treatment. The author found the method exceedingly successful in a case of trigeminal neuralgia and in two cases of severe epistaxis. In some instances it was necessary to repeat the injection on four consecutive days. The syringe should be carefully cleaned after use, as the antipyrin will ruin the instrument if allowed to remain.

Accidental Swallowing of a Stomach-Tube.—LANDSTRÖM describes such a case (*Hygeia*, lvii, 2, p. 198), the patient being a seamstress who was performing lavage of the stomach for round ulcer, and who swallowed a portion of the tube, forty-eight centimetres long and eleven centimetres wide, solid and somewhat inelastic. She fainted, and for some days after suffered from severe, bloody vomiting, nausea, and intense pain at the pit of the stomach and in the bowels. She was unable to take any nourishment. Eight days later Landström detected the foreign body, doubled on itself, in the right iliac fossa, immediately above the centre of Poupart's ligament. Laparotomy was performed by Ekehorn, and the tube was found in the ascending colon, the torn end being clearly seen through the intestinal wall A longitudinal incision of three centimetres was made in the bowel, the tube extracted, and the incision sutured with fine silk threads, two rows being placed through the muscular and serous coats, and another row through the abdominal wall. An aseptic bandage was applied and the patient recovered from the operation without incident.

Carbonate of Guaiacol in Phthisis.—O. TORSTENSSON has used this drug in a great many cases of tuberculosis in the first and second stages, observing an improvement in the general condition, an increase in the body-weight, and a decrease in the local symptoms in the lungs after a few weeks. The dose employed was from 1 to 2 grammes (15½ to 31 grains) twice daily after meals, this being, of course, associated with other necessary measures. He used it especially in combination with injections of cinnamic acid or clysters of carbonate of creasote. The treatment must be continued over a period of some months.

Clinical Notes.

Antiseptics in Midwifery.—Under the heading of "Comparative Studies," the *Practitioner* for March reviews the antiseptic methods employed in certain lying-in hospitals and those recommended by leading authorities. At Queen Charlotte's Lying-in Hospital, London, the following measures are adopted: The patient on admission to the hospital, before entering the labor-ward, is washed from head to foot and clothed in garments provided for the purpose. On entering the ward, before any vaginal examination is made, the vulva and surrounding parts are thoroughly washed with soap and hot water, and, the soap having been removed with plenty of water, the vagina and vulva are irrigated with a solution of perchloride of mercury 1 in 2000. Any rings worn by the obstetrician are removed and the hands well washed with soap and water and scrubbed with a nail-brush. The

hands are then immersed for not less than one minute in a solution of per chloride 1 in 1000. As a lubricant vaselin and perchloride 1 in 1000 are used, and the jar containing it is kept permanently immersed in a basin of 1 in 1000 perchloride solution. When delivery is completed, a warm vaginal douche of 1 in 2000 is given to all patients. Forceps and other instruments before being used are boiled in water in a vessel resembling a fish-kettle in shape. The solution of perchloride of mercury is made from ordinary tap-water, and no acid or other substance is added except some coloring material.

At the General Lying-in Hospital, London, where the antiseptic methods adopted have met with so large a measure of success, the rules are much the same as those above mentioned. The vulva is cleansed and a vaginal douche is given before and after delivery. The lubricant employed consists of glycerin and perchloride 1 in 1000, a small quantity of hydrochloric acid being added to the mercurial solution.

At St. Mary's Hospital and Manchester and Salford Lying-in Institution the methods are as follow: The nurses are taught to thoroughly cleanse the hands with soap and water and turpentine, and then to soak them in a solution of perchloride of mercury 1 in 1000 for five minutes. The vulva is always cleansed with soap and water, and then with the mercurial solution 1 in 1000; but a vaginal douche is only given before labor in cases where there is evidence of septic discharge, as, for example, where there is profuse leucorrhœa or vulvitis. It is, however, given in cases where operative measures are to be undertaken. The lubricant used is glycerin and perchloride, 1 grain (0.065 gramme) to the ounce (31 grammes). After delivery a douche of perchloride of mercury 1 in 6000 is given in all cases.

At the Rotunda Hospital, Dublin, the following plan is adopted: The vulva is washed with soap and then with lysol solution at the commencement of labor. It is believed that this hardens the tissues less than corrosive sublimate. A vaginal douche is not given either before, during, or after labor in uncomplicated cases, nor during the puerperium. Four vaginal examinations are all that are allowed during the entire course of a normal labor. The hands are carefully scrubbed with soap and water and a nail-brush, and the latter is kept constantly immersed in a creolin solution, and, as an additional precaution, is boiled once a week. All soap having been washed off, the hands are soaked and scrubbed with a special brush for one minute in a solution of perchloride of mercury, 1 in 500, to which some tartaric acid has been added. The hands are not dried before examining, and no lubricant is used under ordinary circumstances. If, however, the hand has to be passed into the vagina, then soap is the lubricant preferred. Carbolic soap is usually employed, but no stress is laid on this, as ordinary soap, when once its surface is melted off by hot water, may be regarded as an aseptic substance. Before obstetrical operations the vulva is scrubbed with sterilized tow, soap, and 2-per-cent. creolin solution. The vagina is scrubbed out in the same way with soap and the 2-per-cent. creolin solution.

Professor Tarnier, late Surgeon to the Maternity at Paris, recommends the following plan: The hands are washed and scrubbed with a nail-brush

in a solution of 1 in 4000 perchloride of mercury, soap being used. The depression around the nails is cleansed with a wet cloth, the hands washed in alcohol to remove the fatty substances, and steeped in a perchloride solution. A vaginal douche of perchloride of mercury is always given before and after delivery, and the greatest care is exercised in cleansing the vulva. At the termination of labor an intra-uterine douche of iodine and water is given in all cases, the following formula being the one employed: ℞ Tinct. iodi, 1 fluidounce (31 cubic centimetres); potassii iodidi, 1½ drachms (6 grammes); aq. destil., 32 fluidounces (1000 cubic centimetres). Ft. lotio. Instruments are sterilized in a specially-devised dry-heat sterilizer. The following solution, known as Van Swieten's fluid, is employed: ℞ Hydrarg. perchlor., 1 part; alcohol, 100 parts; aq. destil., 900 parts. Misce et ft. lotio. This lotion is diluted with four times its bulk of water before use; so that the strength then becomes 1 in 5000. Professor Tarnier believes that this is less toxic than mercurial solutions made with tartaric acid.

Professor Winckel, of Munich, adopts the following plan: The genitals are washed with a 3-per-cent. solution of carbolic acid and then dried with salicylated cotton-wool. Vaginal injections before delivery are not necessary in all cases, but when given carbolic lotion of the strength mentioned above is used. The hands and arms after washing are soaked either in a 3-per-cent. solution of carbolic acid or a solution of perchloride of mercury 1 in 1000.

It will be observed that the methods described above admit of being divided broadly into (1) methods for disinfection of hands and instruments, and (2) methods for disinfection of the patient. It is universally acknowledged that the preliminary and most essential step is to thoroughly cleanse the hands with hot water, soap, and a nail-brush, and then to immerse them for a minute in an antiseptic solution, repeating this immersion before each subsequent examination of the patient. The most widely used antiseptic is perchloride of mercury. Some of this is lost by forming an insoluble oxide when mixed with ordinary tap-water; and as distilled water is not available in private practice, the following formula is recommended as insuring a stable solution: ℞ Pulv. hydrarg. perchlor., 10 grains; pulv. acidi tartarici, 20 grains; cochineal, 1 grain. M. et ft. pulv. One powder added to a quart (litre) of water makes a solution of 1 in 2000.

The following routine procedure is suggested as not being unnecessarily complicated, and easily carried out by the general practitioner if a competent nurse is in attendance. Before full term is reached an order should be given to the patient to procure a packet of absorbent cotton-wool, an ounce of sublimated vaselin (1 in 1000), and twelve powders prepared according to the formula given above, or, if preferred, at least two quarts of carbolic lotion (1 in 20). The nurse is instructed to wash the vulva with soap and water as soon as the labor-pains begin, and then thoroughly sponge it with cotton-wool soaked in the antiseptic. A fresh supply of the antiseptic solution is then to be prepared and placed on a table by the side of the bed, together with the jar of vaselin, so as to be in readiness for the doctor when he arrives. Before making any examination the hands are

washed with soap and water, and then immersed in the antiseptic solution at the patient's bedside. The vulva should be sponged from time to time with pledgets of cotton-wool soaked in the antiseptic.

After labor is over, and during the puerperium, three basins should be placed side by side on the wash-stand, and permanently kept there. The first is to be used for washing the hands; the second to contain a solution of perchloride of mercury, freshly prepared each morning by the addition of one of the powders to a quart of water; the third basin to contain a solution of the perchloride, in which are kept the glass vaginal tube and catheter; but, if douching is not employed, the third basin is not necessary. The nurse is instructed to soak her hands in the solution contained in the second basin before doing anything for the patient which involves contact with the genital organs. If this plan is insisted on and explained to the nurse, there is no reason why in most cases in private practice antiseptic precautions should not be carried out as efficiently as within the walls of a well-managed hospital.

An Hitherto-Undescribed Disease of the Skin.—Drs. Duhring and Hartzell, of Philadelphia, in the March number of the *American Journal of the Medical Sciences*, describe the interesting case of a lad, aged 15 years, a mill-hand, who applied at the Hospital of the University of Pennsylvania for the relief of a patch of chronically-inflamed, papular and papulo-ulcerative, slightly-crusted lesions occupying chiefly one side of the neck. The disease had existed three years. The lesions composing the patch, he stated, underwent change from time to time, usually terminating, in the course of several months, in superficial atrophy of the skin in the form of slight, whitish, pitted, irregularly-shaped scars. Itching was not complained of. Upon inspection the disease was found to be peculiar, and a positive diagnosis could not be made. The patch resembled a mild expression of lupus vulgaris verrucosus more than any other well-known disease, and the indolence and slow course of the lesions followed by scarring helped to favor this view. There was no resemblance to acne, acne keloid, sycosis, or tinea sycosis. The regions invaded were the sides of the neck posteriorly, mainly the right side, and to a slight extent the flexor surfaces of the forearm. The patch on the right side of the neck (as shown in the photograph) was of irregular, rounded form, composed of numerous discrete and confluent, firm, irregularly-shaped, dull-reddish, chronic papular, papulo-squamous, and papulo-crustaceous lesions, manifestly representing different stages of the disease. Where several of these lesions were aggregated or confluent, small patches were formed. There were some discrete outlying lesions. In several localities a distinct crescentic configuration existed. The diseased area was warty and rough to the touch, owing to the scales and little crusts on the surface of most of the lesions, especially on those in an advanced stage. On removing them small follicular ulcers were noted, the follicular involvement, however, not being obvious to the unaided eye in all the lesions. That the process was a superficially-destructive one was shown not only by the slightly-crusted, pit-like excavations, but also by the presence of superficial, whitish, acne-like scars left behind upon the healing of the little ulcers.

These atrophic spots, varying in size from a pin-head to a small pea, were numerous and conspicuous, though nowhere deep. The central portion of the main patch especially showed these superficial scars. It was evident that the disease was extending on the periphery, though not regularly, and that the central portion had partially cleared away with scarring; the extension was, however, in no sense sharply defined or marginate, as in tinea circinata, nor was there any indication of a creeping or serpiginous course. It was, however, suggested that the disease might possibly be due to the growth of some fungus, perhaps the trichophyton, as Dr. Duhring had seen a somewhat similar remarkable case many years before, occurring on the hands, which examination showed to be due to the trichophyton.

With the aid of cocaine anæsthesia lesions were excised from the patches upon the neck, fixed in alcohol, imbedded in paraffin, and cut and mounted serially. Several lesions were thus examined, the same alterations being found in all. The rete mucosum was markedly thickened, the papillary layer infiltrated with small round cells, and the papillæ considerably enlarged. At the sides of the papules this enlargement was chiefly longitudinal, but in the centre the papillæ were both longer and broader than normal. Sections which passed through the centre of the lesions showed a large downward prolongation of the rete, which contained a cavity of considerable size, opening upon the surface. This cavity, which occupied the site of a hair-follicle, contained a mass of round cells, granular detritus, altered epithelium, and, what was of most interest, a considerable quantity of mycelium and round and oval spores. The epithelium had disappeared at the bottom of the cavity in some sections, and the mycelium had broken through into the corium, growing between its fibres. In addition to this large cavity there were several smaller ones which did not communicate with the surface, but also contained fungus, together with granular matter. In a few sections isolated mycelial threads were seen growing between the fibrous elements of the corium at some distance from the cavities already described. While this fungus resembled in a general way the trichophyton as seen in tinea tonsurans, it differed from it markedly in size, being two or three times larger. The spores were about $\frac{1}{2500}$ inch in diameter, while the mycelial threads were from $\frac{1}{4000}$ inch to $\frac{1}{2000}$ inch in thickness. The mycelium was for the most part short, in a few instances branched and jointed, and commonly had club-shaped ends. The spores were few in number, the oval-shaped ones predominating. In sections stained with hæmatoxylon and eosin and with Biondi's fluid the fungous elements were, in the first instance, stained a bright rose-red; in the second, a purplish-red, in marked contrast with the tissue-elements. In sections stained with alum-carmine the fungus remained unstained, showing as highly-refractile threads and spores.

Effects of Double Castration on the Enlarged Prostate.—Mr. E. Hurry Fenwick, of London, believes that the operation of double castration, which Dr. J. W. White, of Philadelphia, has proposed for the shrinkage of the enlarged senile prostate, is a valuable and an important addition to the methods of treating the distressing sequelæ of this form of urinary obstruc

tion, for, although his experience is limited to nine cases, yet he has seen sufficient improvement in these to induce him to recommend the operation for certain forms of the disease. (*British Medical Journal*, March 16, 1895.) He gathers that the profession at large is too sanguine as to the immediate benefit to be expected from the procedure, that too pronounced a relief is anticipated from it, and that it is regarded as a panacea for all stages of prostatic obstruction,—views which he regards as untenable. He suggests that those who record their experiences should be careful to recognize and to mention the character and size of the prostate *per rectum* and the length of its channel before and after the operation, for it is only upon accumulated reports of such data that we can be guided to the selection of that form of prostatic enlargement which is best suited for double castration. Accurate estimation of the character and size of the prostate is far from easy, and he is forced to believe that statements describing enormous prostates disappearing in three weeks after orchectomy spring from an erroneous appreciation of the size and shape of the gland. There is no doubt that slow shrinkage of the prostatic tissue, in many of the forms of senile enlarged prostate, ensues upon double castration. Further experience must, however, decide as to whether every form of prostatic growth is thus affected. It is certain that escape from catheter life after castration depends absolutely upon the health of the vesical muscle. The grade of the atony, therefore, should be most carefully estimated before any hopes of relief from catheterization are held out. To promise a confirmed catheter case that orchectomy will do away with the instrument will merely bring discredit on the operation and disappointment to the patient. Even after prostatectomy we are unable to promise such relief if the muscle is hopelessly atonic, and we cannot do so after castration. It is possible that castration, by diminishing the microbic infection from the inflamed senile prostate, will remove a constant menace to the integrity of the kidneys, for it will control the most prolific source of ascending pyelitis.

In his opinion it will prove of value in the following conditions: 1. In reducing bulky outgrowth of the lateral lobes of the prostate. It may be found that the small, tough, fibrous, median or lateral vesical outgrowths will be better removed by suprapubic prostatectomy. 2. In controlling the distress and danger of an inflamed senile enlarged prostate. 3. In lessening the frequency or difficulty of introducing the catheter in advanced or confirmed catheter life. 4. In avoiding the mechanical difficulty of crushing a post-prostatic on a post-trigonal stone, by leveling the base of the bladder, thus rendering the operation of litholapaxy feasible in a condition in which before it was impracticable. 5. In reducing chronic cystitis and recurrent phosphatic calculus in cases of confirmed catheter life.

Quinine in Influenza.—Prof. I. Burney Yeo, of London (*Lancet*, March 2, 1895), protests against the somewhat reckless use of such drugs as salicin and antipyrin in influenza. It is true that these agents produce relief of the immediate symptoms, but he has frequently observed that patients thus treated often have a tedious convalescence, and are subject to recurrent attacks of cardiac debility and other serious sequelæ. Clinical and experi-

mental evidence, in his opinion, goes to show that quinine is a true antitoxin in influenza, and that, in spite of the disagreeable effects which it sometimes causes, it should be mainly relied upon in the treatment of the disease, simply giving a few doses of such drugs as salicin and antipyrin at the onset to afford relief. DR. MARSH, of Macclesfield Infirmary (*Lancet*, March 9, 1895), confirms Dr. Yeo's belief in the efficacy of quinine, but suggests that, since the drug is not completely excreted from the tissues for some days, it is not necessary, in order to produce its specific effect, to give the drug in such large doses as to produce cerebral symptoms; 3 to 5 grains (0.2 to 0.32 gramme) given in an effervescing saline draught every three or four hours markedly controls the course of the disease and rarely gives rise to "cinchonism." The large doses of quinine given on the Continent in this disease appear to be quite unnecessary and not altogether devoid of danger. Dr. Marsh has seen 15 grains, given every three hours, produce marked cardiac depression, particularly in elderly people. Comparatively small doses undoubtedly in many cases exercise a controlling influence on the course of the disease, yet the pyrexia with its attendant symptoms may be but slightly relieved, and for this purpose 3 to 5 grains (0.2 to 0.32 gramme) of phenacetin combined with a few grains of citrate of caffeine act as a safe and efficient antipyretic and anodyne. DR. GRANT, of Elgin, Eng., in commenting on Dr. Yeo's statements, expresses the opinion that the diminished mortality and shortened period of convalescence of the recent epidemics, as compared with the first epidemics observed, are due not to the lessened virulence of the bacillus, but to the fact that antipyrin and similar depressants are being withheld in the treatment. He is convinced that antipyrin was responsible for the pneumonia complicating the disease.

MOSSÉ, of Toulouse, in a recent communication to the Paris Academy of Medicine, also advocates the use of quinine in influenza, as a prophylactic and in the abortive treatment, when large doses should be given; while in serious secondary infections hypodermatic injections should be employed. He has demonstrated by experimental and clinical research that the microbe of influenza cannot live in an organism impregnated with quinine.

Sudden Death After Intubation of the Larynx.—Cases of death following intubation of the larynx being exceedingly rare, that reported by DR. DURAN, in the *Revista de ciencias medicas de Barcelona* (January 10, 1895), is of interest. The patient was a girl of about 3 years of age, brought to hospital a few days after being attacked with pharyngeal diphtheria. The posterior portion of the mouth, the uvula, and the fauces, as well as the nasal fossæ, were invaded by false membrane. Usual treatment producing no result, Aronson's antitoxin was administered, and, as the blood showed a deficiency of oxygen by evening, Dr. Duran decided to perform intubation. His first attempt was not successful, but the second time the tube was introduced easily and without the least violence. For several minutes the child breathed more freely and fully, but suddenly the facial muscles contracted, the eyes opened widely, a slight convulsion occurred, and death followed. Traction of the tongue, artificial respiration, and ether injections were

without avail, death having been instantaneous. The autopsy showed no lesion of the organs, and the fatal termination is attributed to a reflex originating in the larynx, the bulb responding by cardiac paralysis.

Intra-venous Injections in Pneumonia.—PROFESSOR GALVAGNI, of Modena, Italy, describes the case of a robust young man of 19 years, who entered his clinic with left basal pneumonia. The pulse was 120, feeble, and arhythmic. An intra-venous injection of 200 grammes (6½ fluidounces) of chloride of sodium 75 per cent. and bicarbonate of sodium 50 per cent. was made, and within two hours the patient had a chill, followed by abundant perspiration, defervescence being complete in four hours. In ten hours, however, the temperature rose to 39° C. (102.2° F.), but at once fell, and five days after his entrance into the hospital the patient left, entirely recovered. Similar treatment was employed in several cases by Professor Galvagni, and always with similar success. He explains its mechanism by saying that most cases of cardiac paralysis in pneumonia are due to coagulation of blood in the heart, and this the injection prevents. It would naturally be of no value in serious or advanced cases, especially in elderly people, where coagulation has already occurred.

Perfect Recovery of Hearing After Twenty-six Years of Deafness.—DR. F. FAULDER WHITE, surgeon to the Coventry Hospital, describes a case of this kind. (*British Medical Journal*, March 2, 1895.) The patient, aged 35 years, was said to have been deaf from the age of 9 years, and when first seen heard nothing at either meatus, owing to closure of Eustachian tubes. Daily Politzerization was instituted, and in one week she heard, at one-half inch, a feebly-ticking watch; in three weeks at three inches; and after three months hearing became normal. The case is recorded as remarkable for the extent of the recovery after so long a period of deafness, and to encourage tentative treatment in apparently confirmed cases of deafness. The mental development has been most marked since hearing has been established. Before treatment she was a good lip reader, and could make use of a limited number of words. Now, after restoration of hearing, she is obliged to learn the alphabet of sound. At first she could not understand aural conversation at all, but now understands many words when spoken slowly. Her education has been greatly neglected.

Acromegaly, Exophthalmic Goitre, and Glycosuria in the Same Patient.—PROFESSOR LANCEREAUX describes the case (*Semaine Médicale*, February 13, 1895) of a woman subject to migraine and hæmorrhoids, who, at the age of 37 years, coincident with the cessation of the menses, presented symptoms of Basedow's disease, and at the same time glycosuria, with polyuria and polydipsia. The head, the feet, and the hands began to increase in size in a most extraordinary manner, until all the classical signs of acromegaly, as described by Marie, were evident. The author is of the opinion that this complex of pathological conditions has its origin in the same general cause, and that it is, in effect, a vasotrophic neurosis, to which he gives the name of herpetism. This theory renders evident the indication of treatment directed toward the disturbance of the nervous system, bromide of potassium and hydrotherapy responding best to this indication.

An Aid to the Diagnosis of Visceral Cancer.—DRS. BABES and STOICESCO, of Budapest, have found that the microscopical examination of small, subcutaneous, metastatic tumors may be of considerable value in diagnosing cancer of the internal organs. In one case (*Progrès Médical*, February 23, 1895) the generalization of cancer in the skin and subcutaneous cellular tissue, observed during life, constituted an important sign of cancer of the stomach at a point where the diagnosis was almost impossible. In another case of cancer of the uterus, in which the nature of the tumor could not be determined, the examination of a metastatic subcutaneous tumor definitely established the diagnosis.

Recent Suggestions in Therapeutics.

Asthma.—At the moment of the attack, spray rapidly the back of the patient with *chloride of methyl*, from above downward and from below upward. The attack will cease in a few moments; if not, spray lightly the upper part of the chest. If the skin be delicate, as in women, cover the parts with a bit of fine gauze and make the strength of the spray proportionate to the strength of the patient and the violence of the attack. (TSAKIRIS, *Gaz. des Hôp.*, March 12, 1895.)

Biliary Lithiasis.—*Classical Form:* Give subcutaneous injection of the following solution: *Morphine hydrochlorate*, 0.10 gramme (1¾ grains); *atropine sulphate*, 0.01 gramme (⅙ grain); *distilled cherry-laurel water*, 20 grammes (5 fluidrachms). Repeat injection every half-hour until pain ceases. Give every half-hour a wineglassful of pure *olive-oil* flavored with *lemon-juice*. Rub hepatic region with flannel soaked in following liniment: *Hyoscyamus-oil*, 80 grammes (2½ fluidounces); *chloroform*, *Sydenham's laudanum*, each 10 grammes (2¾ fluidrachms). Give ice to suck and let patient sip champagne occasionally.

Abortive Prolonged Form: Order a glass of Vichy every morning, containing 1 gramme (15½ grains) of *salicylate of sodium*. On retiring, the following pill: *Euonymin*, 0.03 gramme (½ grain); *podophyllin*, 0.02 gramme (⅓ grain); *extract of hyoscyamus*, 0.01 gramme (⅙ grain); *confection of rose*, q. s. Daily bath of an hour's duration.

In the Interval of Attacks: Prescribe life in the open air, walking, gymnastics, etc.; avoidance of excessive intellectual effort or moral strain; avoidance of acids, especially tomato, fatty or sweet foods; eggs to be eaten rarely; no gaseous drinks or alcohol. Let patient take a sponge-bath every morning, using a little alcohol in the water, rubbing briskly with a hair-glove. (MALBEC, *Tribune Méd.*, March 13, 1895.)

Burns, Scalds, and Frost-Bites.—Immerse part for several minutes in a 2-per-cent. solution of *carbolic acid*, prick blisters, spray part with solution of *hydrogen dioxide* and cover with strips of *Lister protective*

moistened in *carbolic-acid solution.* Apply over that the usual sterilized gauze and bandage. *Acetanilid* may be lightly dusted on under the *protective*, and sometimes seems to have a happy effect. Change dressings, with the same regard to antisepsis, every other day. (T. S. K. MORTON, *Philadelphia Polyclinic*, March 2, 1895.)

Dysentery.—*Powdered cinnamon* in drachm (4 grammes) doses, mixed with a few drops of water, and made into a ball. To be taken morning and evening, washed down by a mouthful of water. Treatment derived from the Persian. Tried by author for past two years; thirty cases being thus cured, some by one or two doses, the worst by six doses. (SURGEON-MAJOR S. T. AVETOOM, Beluchistan, India, *Lancet*, March 2, 1895.)

Hæmatoxylin as a Nuclear Stain.—Delafield's formula obtained from Weigert: Solution I. Dissolve ordinary *alum* 20 parts in water 200 parts. Solution II. Dissolve *hæmatoxylin-crystals* 2 parts in *absolute alcohol* 12.5 parts. Pour the solutions together and allow them to stand, exposed to the light, in a wide-mouthed open bottle for four days; a considerable sediment, principally consisting of alum, will be found. Filter, then add 50 parts each of *glycerin* and *methyl-alcohol.* Cork tightly and keep indefinitely. Sometimes, when the two solutions are poured together, a faint, transparent, blue color results; sometimes they at once form an indigo-blue solution. When finished, the solution should be very dark purple. When old, it sometimes becomes red. Use as follows: Add enough of the stain to a dish of water to make it sufficiently opaque to prevent one from reading through it. It is better to dilute with ordinary tap-water, as the *salts of calcium* and *magnesium* present intensify the action of the stain. When added to distilled water, it makes a red solution; when to tap-water, a blue one. Spread out the section in a dish of water, and transfer to the stain, carefully spread upon a section-lifter. The sections must not be folded, and must never lie upon each other, as the portions covered in this manner are protected from the stain and will appear much paler than the remainder. Every minute or so remove the section from the stain, wash carefully in clean tap-water, and note the color. If this is not sufficiently intense, replace, allowing to remain for a moment or so; wash it again, and continue this process until exactly the tint desired is attained. The finest possible result can be achieved by making the diluted stain so weak that only the faintest color exists and then allowing the section to lie in it for twelve or twenty-four hours. The color may be considerably intensified and made more purely nuclear by the addition of three or four drops of a saturated solution of *lithium carbonate* to the wash-water, using a second wash-water to remove the *lithium carbonate.* Pass from the wash-water to 95-per-cent. *alcohol*, from this to *absolute alcohol*, then to *oil of cloves*, *oil of bergamot*, *carbol-xylol*, etc., for clearing before being mounted in *Canada balsam.* (J. MCFARLAND, *Philadelphia Polyclinic*, March 2, 1895.)

Incoercible Vomiting of Pregnancy.—Apply the continuous current, placing the positive pole on the clavicle, between the two branches of the sterno-cleido-mastoid, and the negative pole over the umbilicus. Use a current of 10 or 15 milliampères for from fifteen to thirty minutes. This method succeeded in the hands of the author in five cases in which vomiting was so intense as to render provoked abortion almost imperative. (GAUTIER, *Gaz. des Hôp.*, March 12, 1895.)

Indigestion.—*Oil of cloves*, 2 or 3 minims (0.13 or 0.2 gramme); *diluted hydrochloric acid*, 15 minims (1 gramme); *tincture of nux vomica*, 20 minims (1.3 grammes); *compound tincture of cardamom*, 2 fluidrachms (8 cubic centimetres). Mix. To make one dose, given before meals, thrice daily. If there is much pain, give about 3 minims (0.2 cubic centimetre) of *spirit of chloroform*. If acid eructation is severe, give *sodium bicarbonate*, 10 grains (0.65 gramme), instead of the *hydrochloric acid*. If there is attendant constipation, give ½-drachm (2 cubic centimetres) doses *fluid extract of cascara* at bed-time. (J. P. CROZER GRIFFITH, *Philadelphia Polyclinic*, March 2, 1895.)

Lumbago.—If pain is severe, give injection of *atropine sulphate*, 0.001 gramme ($\frac{1}{64}$ grain), with or without *morphine sulphate*, 0.01 gramme ($\frac{1}{6}$ grain), inserting needle to its hilt in painful muscle. Give directions as to diet, clothing, and personal hygiene, and prescribe the following mixture: *Sodium salicylate*, ½ ounce (16 grammes); *potassium iodide*, 2 drachms (8 grammes); *compound syrup of sarsaparilla*, 1½ fluidounces (50 cubic centimetres); *water*, sufficient to make 3 fluidounces (93 cubic centimetres). Mix. Dose, a teaspoonful in water thrice daily, after meals. (S. SOLIS-COHEN, *Philadelphia Polyclinic*, March 2, 1895.)

Monographs Received.

The editor acknowledges, with thanks, the receipt of the following monographs:—

A Practical Theory and Treatment of Pulmonary Tuberculosis, by **Frank S. Parsons**, Philadelphia.——Bromide of Ethyl as an Anæsthetic in Oto-Laryngological Practice, by **A. W. de Roaldes**, New Orleans.——Some Additional Experiences with Behring's Diphtheria Antitoxin and Some Remarks on the Use of Lœffler's Toluol Solution, by **Edwin J. Kuh**, Chicago, Ill.——Three Cases of Bicornis Septus, by **George M. Edebohls**, New York.——Ricerche Istologiche sull' Origine del Linfo-Angioma Congenito, del **Luigi Capitanio**, Bari, Italy.——A Review of Six Interesting Pathological Cases, by **E. R. Axtell**, Denver, Col.——Hygiene of the Anus and Contiguous Parts, by **J. Rawson Pennington**, Chicago.——Notes on Movable Kidney and Nephrorrhaphy, by **George M. Edebohls**, New York.——Multiple Neuritis, with the Development of Unilateral Facial Paralysis Late in the Course of the Disease, by **J. T. Eskridge**, Denver, Col.——Chicago Summer School of Medicine, Announcement, 1895.——Contributo Allo Studio del Linfangioma, del **Guiseppe Zuccaro**, Bari, Italy.——The Technique of Vaginal Hysterectomy, by **George M. Edebohls**, New York.——Ein Beitrag zur Ætiologie der Conträren Sexualempfindung, von **Schrenck-Notzing**, Munich.——Neudorfer's Method of Amputating Extremities, by **A. H. Meisenbach**, St. Louis, Mo.——A Case of Compound Follicular Odontoma Invading the Right Antrum of Highmore, by **A. W. de Roaldes**, New Orleans, La.——Treatment of Empyema of the Antrum of Highmore, by **Robert Levy**, Denver, Col.——A Study of the Mode of Action of Ichthyol in Inflammatory Conditions, by **D. Braden Kyle**, Philadelphia.——Malattie Predominanti nei Paesi Caldi e Temperati, p. **Filippo Rho**, Rome, Italy.——Observations on the Action of Chloroform, by **Bedford Brown**, Alexandria, Va.——A Case of Fracture of the Thyroid Cartilage, by **Thomas B. Eastman**, Indianapolis, Ind.——The Effect of Obstruction in the Upper Air-Passages on the General Health, by **John A. Thompson**, Miami, Ohio.——A Clothing Case for the Army and Navy, and a Device for Transporting the Wounded, by **W. Thornton Parker**, Groveland, Mass.——A Case of Foreign Body (Gold Coin) Engaged in the Ventricles of the Larynx, by **A. W. de Roaldes**, New Orleans, La.——Bacteriological Study of Four Cases of Diphtheria Treated with Antitoxin, by **D. Braden Kyle**, Philadelphia, Penna.——The differential Diagnosis between Diphtheria and Other Diphtheroid Inflammations of the Upper Air-Passages, by **A. W. de Roaldes**, New Orleans, La.

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(End of Editorial Department of Journal for April, 1895.)

Tannigen as a General Astringent.

In an excellent work entitled "Notes on the Newer Remedies," by David Cerna, M.D., Ph.D., Demonstrator of Physiology in the Medical Department of the University of Texas, just issued by W. B. Saunders, Philadelphia, the following occurs with regard to this preparation :—

"Tannigen, or acetyl-tannin, is a compound of acetyl and tannin. This new remedy appears in the form of a yellowish-gray powder, odorless and tasteless, slightly hygroscopic, and melting at 374° F. (190° C.). It is freely soluble in cold alcohol and dilute solutions of borate, carbonate, and phosphate of sodium. Tannigen has been employed with good results in the treatment of chronic diarrhœa, especially those occurring in phthisical individuals. This remedy is administered internally in doses of 3 to 7½ grains (0.20 to 0.50 gramme) and even as high as 60 grains (4 grammes) a day. Locally applied in a 3-per-cent. solution in 5 per cent. of sodium-phosphate solution, Tannigen has rendered good service in the treatment of chronic pharyngitis."

Ovarine.

Dr. E. Houston, of Stanberry, Mo., under date of May 15, 1894, reports the case of a lady, aged 26, who had never menstruated only at rare intervals, and then only a slightly-colored fluid, and at the time she came under his observation there had been no flow for five months. He inquired into her history and found that her health had always been delicate, yet she never considered herself an invalid. He made a thorough physical examination of her case with the view of treating her for sterility. The following objective points were noted : General appearance anæmic ; there was a look of childish innocence in her face, yet blended with an intelligence of a high order ; the muscular system lacked firmness and rotundity ; the uterus was infantile, and the ovaries could not be made out by digital or bimanual palpation. The vaginal stricture indicated loss of muscular integrity. Specula exploration showed an unnatural paleness, and the sound passed the internal os without difficulty. On these grounds he concluded that the sterility and amenorrhœa were due to defective nutrition of the womb and ovaries,—in fact, a general want of blood-supply throughout the pelvic organs. Acting on this opinion, he placed her on Ovarine (Hammond's) in 5-minim doses once per day, and in three weeks the menses were established. The result in this case has been, as it has proven in nearly all cases in which he has used the extracts, highly pleasing, but in this particular case the patient referred to is now in the seventh month of pregnancy, and nothing unusual has attended her progress so far.

Antitoxin Treatment of Diphtheria.

The particular subject of interest before the medical profession continues to be the Antitoxin Treatment of Diphtheria. Some dissatisfaction has been experienced in certain directions with the results obtained. It may be advisable for physicians to remember that it is only with the purest grades of the serum that the results can be uniformly satisfactory. Significant in connection with the varying results obtained is the fact that, during the recent brief suspension of the delivery of Dr. Aronson's antitoxin, much of the unfavorable clinical data has been reported. A recent issue of the *British Medical Journal* reports a case so interesting that we reproduce it: A patient, aged 26, was admitted to the Carlisle Fever Hospital on the second day of illness, whose symptoms of diphtheria were fully developed. On the succeeding mornings 15 minims of Dr. Aronson's antitoxin were injected, each injection being followed by an initial fall of temperature. On the second day of treatment the patches began to disappear, and the albuminuria that was present prior to the first injection disappeared after the injection, again recurring for a short time after ten days.

THE

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Selections from Society Proceedings.

GERMANY.

CONGRESS FUR INNERE MEDICIN, MUNICH.

The Antitoxin Treatment of Diphtheria.—The discussion on this subject brought out an accumulation of evidence in favor of the new treatment for diphtheria. PROFESSOR HEUBNER, of Berlin, gave the statistics of 3000 cases treated in Berlin during the year 1894,—1332 by ordinary methods, with a mortality of 39 per cent.; 1390 by the serum, with a mortality of 21 per cent.; and 207 cases of his own, 26 of which were complicated, with a mortality of 13 per cent., or of 10 per cent. if the complicated cases were not included. An interesting feature of his report was the account of the modifications induced by the use of antitoxin in the disease. Normal diphtheria is characterized by a rise of temperature for one or two days, then by a fall, then a new rise of temperature, corresponding to the laryngeal symptoms. When antitoxin is given a second rise of temperature does not occur, and the maximum of the local symptoms is manifested on the sixth day instead of the eighth. In other words, the false membrane is much more readily detached by the use of the serum, which notably arrests the process and prevents its extension to neighboring parts. This explains the influence of early injections upon the prognosis and upon the mortality, which in Professor Heubner's personal practice was *nil* in the cases treated on the first day of the disease, 4.6 per cent. in those treated on the second day, and 16 per cent. when the cases were treated from the fifth day and after.

PROFESSOR BAGINSKY reported 525 cases treated by the serum with a mortality of 15 per cent., instead of 41.1 per cent. obtained in his clinic by other methods from 1891 to 1894. The clinical evolution of the disease seemed to be much milder when the antitoxin was used, and the general

health of the patient was better. He had also made prophylactic injections in 124 cases, not one of which contracted diphtheria. He had observed a notable modification of the heart-symptoms in the cases treated by antitoxin, the death-rate from cardiac causes being but 0.6 per cent. in his cases, while previously it had been 26 per cent. Intubation could be more readily performed, and tracheotomy became almost unnecessary. The serum had no effect on the kidneys, and phenol was not observed in the urine. Paralysis, however, was more frequent than before, possibly because more children lived.

Professor von Ranke, of Munich, reported 124 cases treated with the serum, with a mortality of 22.4 per cent. In preceding years the death-rate at Munich had always exceeded 41 per cent. He also had been able to replace tracheotomy by intubation. Formerly, the danger of the latter operation was from the possibility of the disease descending and of necrosis of the larynx occurring at the point of insertion of the tube. These complications need not be feared when antitoxin is used, while it is not necessary to leave the tube in place for as long a time as formerly.

Dr. Seitz, of Munich, treated 140 cases with the serum, with equally good results, and Professor Widerhofer, of Vienna, 300 cases, with a mortality of 14.3 per cent., excluding complicated cases; Professor Rauchfuss, of St. Petersburg, had a death-rate of 21 per cent. instead of 55 per cent.; Professor von Mering, of Halle, 5 per cent. instead of 28 per cent.; Professor von Noorden, of Frankfort-on-the-Main, 23 per cent. instead of 45 per cent.

The general opinion of the Congress, with the exception of a couple of speakers, was that, although from a scientific stand-point the mode of action of antitoxic serum was not definitely ascertained or understood, it was advisable to continue its use, in view of the undoubted benefits observed.

GREAT BRITAIN.

Royal Medical and Chirurgical Society.

Affections of the Nervous System in the Secondary Stages of Syphilis.—Mr. Jonathan Hutchinson, in opening a debate on this subject, drew the following conclusions, which he offered as the basis for discussion (*Lancet*, March 2 and 16, 1895): 1. The nervous system might suffer in very various ways during the secondary period of syphilis, and it was very important to recognize this fact, since the affections were usually acute and destructive unless prompt treatment was adopted. 2. It was very exceptional that any disease of the nervous system occurred earlier than the sixth month. 3. Many, perhaps most, of the affections of the nervous system in the secondary period were secondary to disease of the blood-vessels. Under this head were included extensive implications of the minute arteries of the pia mater, whether of the brain or cord. 4. Amongst the diseases which were probably primarily of the nerve-structures themselves we might recognize (*a*) acute affections of the eye and ear, of the latter sometimes attended by

paralysis of the portio dura; (*b*) acute forms of polyneuritis, usually symmetrical and transitory; (*c*) a peculiar and very definite form of paraplegia due to transverse myelitis; (*d*) certain rare and peculiar forms of hemianæsthesia. 5. It was not disputed that at much later periods in the course of syphilis affections closely similar to the above might occur; but it was believed that when they did so they were much slower in onset, less severe and more chronic in progress, and less amenable to specific treatment. 6. The prognosis of these affections was good up to a certain point if efficient treatment were commenced early. 7. It was believed that these early affections of the nervous system in syphilis occurred almost invariably in those in whom the treatment in the early stages had been neglected.

Dr. Gowers only knew, from personal observation, of syphilitic disease of the larger arteries of the brain. He knew of no disease of the arteries of the spinal cord that could be called syphilitic. With regard to syphilis of the smaller arteries of the brain, there was an observation by Dr. Barlow which established the fact that there might be a syphilitic disease of the minute arteries scattered throughout the whole substance of the brain. The disease of the large arteries occurred usually during the first seven or eight years after the acquisition of syphilis, and was absolutely identical in its characters and effects and distribution from first to last, affecting the middle cerebral and basilar arteries by preference, and producing the same effects at all periods. It could not be distinguished in any case as secondary or as tertiary by naked eye or microscopical evidence, though its aspect was materially changed when the patient had been subjected to a course of antisyphilitic treatment. A fact of practical importance with which he had been much impressed was that the dose of iodide of potassium as usually given—say, 15 grains (1 gramme) three times a day—after two or three months ceased to influence the disease, which again became aggressive. Though the microbe of syphilis had not been discovered, it was necessary, in order to obtain a real grasp of the disease, to conceive it to be due to a specific organism. Besides the arterial disease there was the gumma, which was certainly of less frequent occurrence than was the arterial disease during twelve years after the primary infection. The two principal predisposing causes appeared to him to be youth (all his cases had occurred in young people, chiefly between 18 and 29 years), and injury to the head, whether received previously or subsequently to infection. Other predisposing causes were neurotic inheritance, sexual and alcoholic excesses, and undue mental strain. The chief differences between early and late nerve-syphilis appeared to lie neither in the nature of the lesions (for arteritis and syphiloma occurred both early and late) nor in their seat, as no portion of the nervous system appeared to be safe from the inroads of the virus at either period. Early nerve troubles were, however, more acute in their appearance and more amenable to specific treatment, while tertiary affections had a slower and more insidious course, with a tendency to end in general paralysis. Nervous affections, after the acute exanthemata, such as paralysis, the delirium of collapse, etc., might appear at a still earlier period,—that is, before or immediately after defervescence,—while a considerable

interval between the cessation of the fever and the appearance of nerve troubles was exceptional. Influenza stood very much in the same line with the eruptive fevers in this respect. He had seen a few cases of what he might call tertiary nerve affections after influenza, but in no case had the interval between their appearance and the primary attack exceeded six months; while insanity, general paralysis, encephalitis, myelitis, and neuritis had frequently followed the attack at a very short notice.

Dr. Althaus spoke strongly on the necessity of the full use of mercury in the cases under consideration. He preferred the hypodermatic use of the metal and injected the soluble perchloride, which was readily absorbed and eliminated, in acute and threatening cases; and an insoluble preparation, where the mercury was rubbed up with carbolic oil and lanolin, in the more chronic forms of the disease. The latter preparation was slowly absorbed and eliminated, and need only be injected once a week, while the perchloride should be injected daily, for some time. No other remedy could be relied upon with confidence in the gravest emergencies of this kind, although even mercury was not infallible.

Sir William Broadbent did not think that morbid anatomy could ever have convinced us that the manifestations of the third stage of syphilis belonged to the same disease and were produced by the same poison as the manifestations of the first and second periods; and, if we extended our definition of the tertiary stage to include locomotor ataxy and general paralysis of the insane, pathological anatomy would have been still more at fault. He agreed with Dr. Gowers that the ultimate clue to the diversities in this disease would eventually be found by an inquiry into the causative microbe or microbes and their toxins. The secondary lesions were characterized by their symmetry; the tertiary by their want of simple grouping. The secondary lesions were caused by a disturbance of nutrition on the side of the blood; the tertiary lesions, on the other hand, were tissue changes initiated by blood changes, but which had ceased to have any immediate relation to blood changes. He confessed that, from his early work, he had been of opinion that the effects of secondary syphilis were manifested upon the skin, mucous membranes, and blood-vessels, and were seldom of a destructive character. The tertiary lesions, besides involving the tissues in these situations, also involved the deep-seated viscera and nervous system. The late manifestations of syphilis were attributed either to the results of damage to the vessels done during the secondary period or to gummatous growths. Hence, when he came across paraplegia during the first two years of syphilis, he had been in the habit of looking upon it as a precocious tertiary manifestation. He referred to the case of a patient, aged 24 years, who came under treatment six months after the chancre-signs of paraplegia began to show themselves. Another man, aged 40 years, came under treatment with definite signs of paresis; he had acquired syphilis a year previously. These cases were clearly due to the effects of secondary syphilis upon the spinal cord, and he regarded it as really a myelitis, and not a primary affection of the vessels. He had seen epilepsy in the second stage of syphilis which had yielded to treatment, and there was no recurrence after

twenty years. Certain cases of spinal meningitis he had also attributed to secondary syphilis. In one such case there were pain and ataxic gait in the legs and rapid wasting of the muscles in the arms; the meningitis seemed to have affected the posterior aspect of the cord at the lower part and the anterior aspect of the cord at the upper part. Recently he had seen two cases in which a zone of anæsthesia rapidly developed.

To one case of gumma there were three or four of arterial disease produced by syphilis. Gummata always sprang from the membranes, never from the brain-substance or from the substance of the spinal cord, and when present in the cerebral substance they could always be traced to some fold of the membranes. It was probable that a similar inflammation of the membranes was the origin of the indurated form of pachymeningitis sometimes met with in the cord. Small gummatous growths had also been found upon the nerves. Though locomotor ataxy was a sequel of syphilis in such a vast proportion of cases that there must be a causal relationship between them, yet the ataxy could not be cured by antisyphilitic treatment. If locomotor ataxy were compared with the effects of alcohol upon nerves or of other chemical poisons, such as arsenic and lead, or those produced by diphtheria, there could be no doubt that the ataxy was the result of a chemical poison left behind by syphilis. The condition of inflammation might be associated with gummatous deposit in varying degree, and, the more acute the condition, the more would the inflammatory phenomena preponderate. In the cases of acute cerebral meningitis which were sometimes checked or ended by mercury the inflammation was very acute, and there was little or no time for the production of characteristic gummatous tissue. He doubted at the present time even more than he did in 1880—when he published his work on "The Diagnosis of Diseases of the Spinal Cord"—whether syphilitic arterial disease played any part in the production of acute spinal myelitis. The fact that acute transverse myelitis was frequent in the subjects of constitutional syphilis had long been a familiar one; but there was also this conspicuous fact about these cases, as about all cases in which inflammation preponderated over tissue-production, that, in proportion as this was the case, antisyphilitic treatment failed. Who that had kept in touch with the therapeutics of the past could have any doubt regarding the influence of mercury upon simple inflammation, and who was there who could place any confidence whatever in mercury as a test of the syphilitic nature or otherwise of acute inflammation? These cases, treated as energetically and promptly as possible, ran a course absolutely indistinguishable in every case from that of cases of transverse myelitis in which syphilis could be absolutely excluded. The syphilitic and non-syphilitic cases ran a parallel course. The same applied to arterial disease of the brain. It was only in the cases in which there was not the tendency to recovery which all acute processes involved that we could place any confidence in the significance of the antisyphilitic treatment. He quoted the case of a patient, who had an indurated cellulitis in the region of the spine, who was not benefited by iodide of potassium, but who recovered under mercury. He found it difficult to judge whether to class this as a secondary or a tertiary lesion.

Dr. Althaus related a case of hemiplegia which had come on eight months after infection and had been diagnosed and treated as hysterical and got steadily worse until specifically treated. Two years have been mentioned as the earliest period when specific brain-lesions would become developed; but he had himself seen a characteristic form of headache, followed presently by epileptiform seizures and hemiplegia, three months after infection; and another case in which extensive disease of the cerebral arteries, with softening of brain-tissue and other characteristic nerve-lesions, had developed in the same period. He had met with several cases of analgesia in the secondary stage, and thought that this would be more frequently found if it were looked for. Acute multiple neuritis was no doubt sometimes the cause of the more or less general paresis with anæsthesia seen in the secondary stage, but acute encephalitis, ascending myelitis, and poliomyelitis might also occur during that period. He related a case of tabes which had become acutely developed seven months after infection, the patient making a very fair recovery under specific treatment. Early neuritis of single nerves was not uncommon, and he had found that the portio dura was more apt to suffer thus early, while in the tertiary stage the third nerve was more frequently affected. He had also seen neuritis of the sixth and of the ulnar nerves four and six months after infection.

Dr. Ferrier said that all neurologists looked upon syphilis as one of the most potent factors in diseases of the nervous system. The lesions might occur at any time; those which came under his notice were usually in the later stages of syphilis. He was not prepared to admit that syphilitic diseases of the nervous system should be separated into a distinct—a nosological—group. Jacksonian epilepsy was frequently caused by syphilis; so were hemiplegia, hemianæsthesia, and Bell's paralysis; and so also were the affections of the spinal cord, which had been recently erected into a special group by Erb. He knew of no way of distinguishing these cases from others which were not syphilitic. He quoted five cases of the gradual type described by Erb. The first was a man, aged 35 years, who developed the symptoms two years after the chancre; the second, in a man aged 44 years, began a year after the chancre; the third, in a man aged 44 years, began ten years after the chancre; the fourth, in a man aged 44 years, began six months after the chancre; and the fifth, in a man aged 41 years, began thirteen years after the chancre. He then referred to five cases of sudden acute paraplegia. The first, in a man aged 25 years, began six months after the chancre; the second, in a man aged 25 years, began eighteen months after the chancre; the third, in a man aged about 30 years, began eight years after the chancre; the fourth, in a man aged 32 years, began two years after the chancre; and the fifth, in a man aged 23 years, began three years after the chancre. He then mentioned three other cases in which the disease was of the gradual type, and in which there was no history of syphilis, the first being in a man aged 40 years, the second in a man aged 33 years, and the third in a man aged 61 years. These three last cases correspond precisely with Erb's syphilitic group. Sudden paraplegia occurring in syphilitic individuals might turn out to be only the prelimi-

nary stage of a disseminated sclerosis; and he referred to two instances, both males, aged 30 and 38 years, respectively, who illustrated this point. So far as the symptomatology of the spinal lesions went, he was unable to distinguish the syphilitic from the non-syphilitic cases.

Dr. George Ogilvie quoted a number of statistics to show that the lesions of the nervous system to which Mr. Hutchinson had alluded had been recognized for more than twenty-five years as occurring in connection with syphilis, that the symptoms often came on within a few months of infection, and hence belonged to an early stage of the dyscrasia, and all alleged that the disease showed a tendency to improvement, if not to recovery. He gave a list of the single cases of nervous disease occurring early in syphilis which he had been able to collect, and he referred to a large series of figures by Fournier and others, showing that a considerable percentage of the nervous troubles ensued within a year from infection. The specific dorsal myelitis which had been described was only one of the many nervous manifestations of syphilis that might occur early, and, though the myelitis was more common in the early stage, yet it might occur also later. It had been said that these early lesions were symmetrical, but the symmetry was due to the seat of the affection; it was symmetrical because it was spinal rather than because it was secondary. The affection of the brain and of single nerves showed no tendency toward symmetry. There were two other transitory nervous symptoms often observed besides the analgesia which Mr. Hutchinson had described,—an increased irritability of the superficial and deep reflexes, and an hyperæmia of the optic discs; the latter was said to occur in 30 per cent. of syphilitic patients. The irritability was probably to be explained by an alteration in the blood-supply of the nervous system similar to that to be witnessed in the optic disc. The analgesia, he thought, might be of hysterical origin.

Mr. Cotterell said that the primary infection might be so mild that it would escape notice, and the patient would then deny the history of syphilis. Locomotor ataxy and general paralysis were not truly placed in the tertiary stage of syphilis, but really should be regarded as forming a fourth stage.

Dr. F. J. Smith mentioned the case of a man, aged 28 years, who had suffered from a chancre eighteen months before the appearance of the symptoms. In July last he was stunned after a fall from a cart; later he developed a condition of typical paraplegia. The symptoms appeared to be due to neither a vascular nor a gummatous change, but were probably produced by a diffuse infiltration of leucocytes. He should describe Dr. Ferrier's cases of disseminated sclerosis as typical of syphilis; certain damaged areas had gone beyond the reach of iodide of potassium and mercury, but had not been absolutely killed; in these areas a slow sclerotic change had occurred, producing the symptoms complained of.

Mr. Hutchinson, in reply, commented on the interest of at least three observations to the effect that, in cases of paraplegia in which sensation was not lost, bed-sores, nevertheless, developed. One outcome of the debate was a strong emphasis of the fact that a majority of the cases of the nervous

manifestations of syphilis did occur in the early periods. He knew that many such cases had been recorded, but they had nearly all been described as precocious tertiary manifestations. If we attempt a natural definition of syphilis we should describe the second stage as the blood-stage, during which the patient should not marry, as he was still liable to infect his wife and his offspring. If this definition were accepted, then what Fournier and others regarded as manifestations of a tertiary stage we would call secondary, or, at any rate, "blood-stage" cases. Dr. Gowers appeared to regard the tertiary phenomena as due to a chemical poison left behind by the syphilitic microbe. He himself regarded the tertiary phenomena as local phenomena due to an implication of cell-structures and leading to cell-growth; but this did not imply the existence of a poison still circulating in the blood; he did not believe that the blood was infected in any way in tertiary syphilis. Dr. Gowers had implied that the syphilitic remedies were not so useful in the purely-inflammatory manifestations of syphilis; but, in the inflammatory affections of the skin, mercury certainly was very useful. Dr. Ferrier's more typical cases of acute paraplegia appeared to occur during the early period of syphilis. The advisability of forming a special group of these syphilitic nervous manifestations has been doubted; there was no doubt that they were not absolutely special to syphilis, for he had often held that syphilis imitated, but did not create; yet, nevertheless, as with skin syphilitic troubles, there were peculiarities about them which enabled skilled observers to say that they were probably syphilitic, and for that reason they were worthy of being put in a separate class. He had seen very few cases of acute paraplegia which were non-syphilitic and which recovered.

West Sussex District Society.

On Delivery in Certain Cases of Impaction of the Trunk of the Fœtus.—Prof. Herbert R. Spencer, of University College, London, gave some practical points in connection with those cases of head presentation in which, after delivery of the head, it is found that the child's body will not pass through the pelvis without reducing its size. In such cases it is sometimes impossible to deliver the child's body unmutilated after the head has been born, especially through a contracted pelvis. Apart from the rare cases of double monster and of tumors external to the child's trunk, the difficulty may be due to the large size of the child. The largest fœtus he had ever seen weighed 13½ pounds (6.2 kilogrammes), and required mutilation on account of its great size; but through a small pelvis a child of half this weight may be unable to pass.

With a normal pelvis the obstruction formed by the child's trunk may be due to pathological conditions either in the serous cavities or in the viscera. Disease enlarging the thorax to any considerable extent is very rare. A slight serous or bloody effusion in the pleura is very common, and he had once met with acute pericarditis in a newborn child; but these effusions very rarely enlarge the thorax sufficiently to cause obstruction in labor. The trouble will almost always be found in the abdomen. One of

the most common causes of obstruction is distension of the child's abdomen with the gases of putrefaction,—a somewhat rare occurrence even in fœtuses which have been dead for some time. It is, however, a good rule, in all cases of obstructed labor, to percuss the uterine tumor; a tympanitic note will indicate the cause of the obstruction. Another not infrequent source of distension is ascites or peritonitis, by which sometimes the belly is distended to an enormous size. He had seen the vagina distended sufficiently to form an abdominal tumor, and great distension of the bladder and uterus had been met with by other observers; but the only other causes of obstruction which he had personally met with have been distension of the colon by meconium in cases of imperforate anus, cystic kidneys, hydronephrosis, and distended ureters, and enlargement of the liver and spleen in syphilitic children. The diagnosis of the cause of obstruction can usually only be made by careful exploration under anæsthesia. The question of treatment then arises. Traction upon the child's head in order to deliver the trunk should be made with caution and judgment; the employment of great force has caused rupture of the uterus.

If judicious traction fail to bring down the trunk it may be necessary to reduce the width of the child's shoulders. With this object he had found it a useful plan to snip through the clavicles with scissors; then, if necessary, to pass a blunt hook into the axilla and thus bring down the arms. If delivery is still impossible, it may be necessary to remove the head in order to gain room for further manipulations; but before decapitating it is advisable to seize the neck with a strong volsella furnished with interlocking teeth, which will prevent the trunk from receding out of reach. Usually not much advantage is gained by opening the thorax, and the broken ribs are troublesome. The hand should be passed up to the abdomen, which should be opened with the scissors or the perforator, when, if the obstruction is due to gas or liquid effusion, the obstruction is immediately relieved and delivery effected; in other cases it may be necessary to remove the abdominal viscera.

In transverse presentations it is rarely that version cannot be performed, and in impacted transverse presentation it is very rarely that decapitation is impossible. He had twice met with cases in which neither operation was possible. In both instances the pelvis was contracted and the soft parts œdematous, and in one there was the complication of placenta prævia. The uterus was retracted and as hard as a board; the back of the child presented; it was impossible to introduce the hand far enough to perform version or decapitation. He successfully adopted and recommended the following method of treatment in such cases: Make an incision through the skin of the child's back and cut through its spine with scissors; then apply Braxton Hicks's cephalotribe (the points of which meet when the instrument is closed) to the sides of the trunk of the child and screw up the instrument. By making traction with the cephalotribe the soft parts are brought down and may be cut through with scissors. The delivery of the two halves of the child's body then presents no special difficulty.—*British Medical Journal*, April 13, 1895.

CLINICAL SOCIETY OF LONDON.

Nephrectomy for Renal Adenoma.—MR. MALCOLM showed a child, aged 4¼ years, on whom nephrectomy had been performed for adenoma two years and four months ago. The interest of the case lay in the long survival of the child after operation. He had removed the right kidney and a tumor which had been regarded as a malignant adenoma, the mass being of oval shape and measuring six inches by four inches. This was done on November 15, 1892, the child being then under 2 years of age. When he had recorded the case, in January, 1894 (*Clinical Society Transactions*, vol. xxvii), he had thought that only one other child had survived nephrectomy for neoplasm more than a year, and that in this case death from recurrence had taken place after eighteen months. In the debate, however, Mr. Sutton had directed attention to two cases operated on by Dr. Abbe, of New York (*Annals of Surgery*, January, 1894), in which the children, aged, respectively, 2 years and 14 months at the dates of the operation, had survived. Mr. Malcolm was able, from a private communication, to say that both Dr. Abbe's patients were recently alive and well. One of them would have lived after operation three years on April 12, 1895, and one was operated on November 20, 1892, five days after his own case which he presented before the society. The child was quite well and freely secreted urine of good specific gravity and free from albumin. The tumor had consisted almost entirely of tubules lined by columnar epithelium and elongated processes of epithelial cells which did not show any lumen. As such tumors usually contained also cells resembling striped muscle-cells, and as these were absent in this case, he had thought that the peculiar structure of the tumor might account for the good result. This view was negatived by the fact that in one of Dr. Abbe's cases similar tubules were associated with sarcomatous tissue, while the others consisted of striped muscle-cells, round and spindle-shaped cells. If the result were not due to some peculiarity in the nature of the tumor, the only other suggestion he could make as to the cause of the prolonged immunity was that he removed the growth very freely, including the capsule and a mass of enlarged glands.—*Lancet*, March 30, 1895.

PORTUGAL.

FIRST PORTUGUESE CONGRESS OF TUBERCULOSIS.

In reporting the proceedings of the First Congress of Tuberculosis held in Portugal, DR. LUCIO DA ROCHA states (*Semaine Méd.*, April 3, 1895) that the simple fact that 20,000 deaths occur annually from that disease in Portugal, which has a population of 4,500,000, was sufficient to call forth a large attendance from physicians.

M. AUGUSTO DA ROCHA, of Coimbra, reported fifty-six cases of hæmorrhagic pulmonary tuberculosis ending in death, observed by him since 1876. These patients usually feel but a slight general malaise, accompanied by want of appetite and some expectoration. Stethoscopical signs are absent,

hæmoptysis supervenes suddenly, and death immediately follows. The speaker gave the name of hæmorrhagic pulmonary tuberculosis to these cases, which he considered as a new variety, on account of the progress and special termination. As regarded the pathogeny, the bacilli probably lodged in the inner wall of a vessel of medium calibre, and the tubercular nodules, in the course of their development, ruptured the vascular wall and the adjoining bronchus, leaving a free passage for the blood.

M. Espina y Capo, of Madrid, related seven similar cases observed in his clinic and called attention to two important points: first, subjects affected with this variety of tuberculosis nearly always suffer from attacks of fever which may be mistaken for malaria; and, second, it is possible to perceive, by plessimetric percussion, a certain dullness at a given point in the thoracic wall. The absence of stethoscopical signs he attributed to the central and circumscribed character of the lesions. He did not agree with M. da Rocha as to the pathogeny, as in three cases he had found at autopsy that the cavities were in the central portion of the pulmonary parenchyma, one communicating with an artery and a bronchus. He believed that increased size of the cavities led to a laceration of the vessels and bronchi, which was followed by hæmorrhage.

M. Espina y Capo estimated the mortality from tuberculosis in Madrid to be 12 per cent. The greatest danger of infection was from the sputum, and the next greatest from tuberculous meat and milk. He recommended, as prophylactic measures in the great centres, the compulsory disinfection of clothing and linen in the pawnshops; the cremation of patients dead from tuberculosis, or, at least, the disinfection of the bodies and interment at a great depth; the interdiction of marriage between the tuberculous; and the creation of maritime hospitals. Individual prophylaxis could be obtained by strengthening the organism so as to resist the ravages of the disease and by carefully disinfecting all tuberculous emanations from man and animals.

M. Lopes Vieira, of Coimbra, stated that it was not sufficient to know that the Koch bacillus exists in the air, water, and food, and in tuberculous individuals, but that its frequency must be established in order to insure prophylaxis. The confined air of the rooms of phthisical persons, the air of populous centres, and the butter, meat, and milk of tuberculous animals appeared to him to be the potent agents in the dissemination of the disease, man being the most potent of all, through the sputum, secretions, and suppurations. He regarded the method of obligatory declaration adopted in some countries and the isolation of the patient from society as an egotistical and cruel prophylaxis. He proposed a certain number of measures, some to be in charge of the physician, some in the hands of the government, and the organization of conferences for the purpose of disseminating information as to prophylaxis, and assuring their being carried out.

M. Paula Nogueira, of Lisbon, called attention to the frequency of bovine tuberculosis in Portugal. Of 567,840 adult animals 1136 were found to be phthisical,—a proportion of 0.2 per cent. In Portugal, as elsewhere, the animals giving the most milk are those most frequently affected;

but, a curious fact, the animals belonging to the race employed for bull-fights seem to be especially subject to the disease, although they live in the open air and almost in a wild state. The speaker regarded the measures at present adopted as insufficient to prevent the spread of the disease, especially in milch-cows, and proposed the use of tuberculin as a diagnostic measure, numerous personal experiments, as well as testimony from other countries, showing that it was a most valuable element in prophylaxis.

UNITED STATES.

Boston Society for Medical Improvement.

A Case of Pancreatic Cyst Successfully Treated by Drainage.—Dr. Maurice H. Richardson described the case of an Italian laborer, aged 26 years, who had always been well and strong up to the time of his present illness. He first noticed a painless swelling in the pit of the stomach six months before operation. This swelling gradually grew larger, and became so painful that he could not sleep at night. There was no interference with digestion or bowel. The appetite was good. The pulse and temperature were normal; the urine contained nothing abnormal. There had been some loss of flesh. The general appearance was poor, and the face cachectic. A non-resonant, fluctuating tumor, as large as an adult head, was found in the epigastrium, a little to the left of the median line, so large as to interfere seriously with his comfort, embarrassing respiration, and distending tensely the upper half of the abdomen. Dr. Richardson made a diagnosis of cyst of the pancreas, from the position of the tumor and from the history of the case. Immediate operation was decided upon; for, though the patient's condition was not serious, it clearly indicated the necessity of interference. A cut was made between the umbilicus and the ensiform cartilage, the stomach and transverse colon presenting on opening the peritoneum. The omentum having been carefully separated, the tumor was brought into view and its contents aspirated. According to Dr. W. F. Whitney, who examined the fluid afterward, it was viscid and of a dirty-gray color, the reaction alkaline, and the specific gravity 1008. There was about 1 per cent. of albumin, a considerable amount of mucin, and a little sediment which showed an occasional fatty-degenerated cell. The fluid did not emulsify fat and had no diastatic action or digestive properties.

About 2 pints (1 litre) of this fluid were withdrawn by aspiration. The parts about the exposed portion of the tumor were then walled off with gauze, and a free opening was made by which about 2 quarts (litres) of fluid escaped. Exploration with the finger showed a large cavity situated in the retroperitoneal space usually occupied by the tail of the pancreas. The bodies of the lumbar vertebræ could be felt, as well as the pulsations of the abdominal aorta. No stone could be detected. Separation of the tumor was attempted; but, on getting into the deeper parts, the adherence to the surrounding structures was so intimate and the blood-vessels were so numerous that no further efforts at enucleation were made. The cyst-wall

was stitched to the abdominal wound and a large drainage-tube was inserted. The subsequent history was marked by rapid diminution in the amount of fluid discharged. Three weeks after the operation a specimen was sent to Dr. Whitney and found to possess all the characteristics of pancreatic fluid.

Nine weeks after operation the cavity of the cyst was found to be obliterated, nothing remaining but a sinus through which a probe could be passed nearly to the bodies of the lumbar vertebræ.

In the surgical treatment of pancreatic cysts the important question to be decided is between drainage and radical removal of the sac. In two previous cases reported by Dr. Richardson drainage in the same manner proved effectual. In one the discharge grew gradually less and the wound became perfectly healed in a few months. A second healed perfectly; but a year or two later the cyst re-appeared and proved fatal. A second laparotomy was performed for symptoms of acute intestinal obstruction due to pressure upon the duodenum by the refilled sac. At the autopsy a large opening was found between the cyst and the stomach, the cause of death being acute obstruction. A third case, though of doubtful pancreatic origin, was cured by complete extirpation of the cyst. He is of the opinion that as complete healing follows drainage in most cases, and as the danger is slight, it is best to follow that method, as a rule. If the cyst can be easily separated from its attachments and thoroughly extirpated without excessive hæmorrhage, it seems to him best to attempt such a procedure, in view of the possible re-accumulation of fluid, with its remote dangers, as in the second case cited. The attempt at enucleation should be abandoned, however, as soon as it is evident that the cyst is so thoroughly incorporated with the surrounding pancreatic tissues that it can be separated only by cutting.—*Boston Medical and Surgical Journal*, March 21, 1895.

JOHNS HOPKINS MEDICAL SOCIETY.

Uretero-Cystostomy Seven Weeks After Vaginal Hysterectomy.—DR. HOWARD A. KELLY presented a patient who had entered the hospital in August, 1894, with an extensive carcinoma of the cervix, for which Dr. Russell performed vaginal hysterectomy. The disease had extended so far out into the broad ligaments that he was obliged to place the ligatures at a greater distance from the cervix than usual. She recovered rapidly from the hysterectomy, but retained as a sequel a ureteral fistula in the vault of the vagina near the middle of the cicatrix. From this there was the usual constant leakage of urine, although she regularly passed the urine accumulating in the bladder from the other kidney. From a simple vaginal inspection it was impossible to say whether the flow from the cicatrix came from the right side or the left. It clearly did not come from the bladder, for it remained unchanged by the injection of a sterilized solution of milk into that viscus. To decide which was the severed ureter, Dr. Kelly placed the patient in the knee-breast position and introduced his No. 10 cystoscope, when the bladder filled with air and he was able to inspect the ureteral

orifices. By introducing a searcher into the left ureteral orifice he found that this ureter was intact as far as the posterior wall of the pelvis. Upon introducing the searcher into the right ureteral orifice it could not be carried in more than two centimetres, on account of meeting an impassable obstruction. The urine was seen flowing from the left ureteral orifice while nothing escaped from the right side. The demonstration was thus complete that it was the right ureter which was injured and the left was intact.

Having cleared up the diagnosis in this way he operated, October, 1894, —seven weeks after the original operation. The patient was placed in the Trendelenburg position and an incision twelve centimetres long was made through abdominal walls loaded with fat. Every step throughout the operation was embarrassed by the obesity of the patient. After opening the abdomen, the large fat omentum and intestines were dislodged from the lower abdomen and pelvis with great difficulty and held away by means of cotton-gauze pads. The end of the ureter could not be found on the pelvic floor on account of the rigidity and inflammation surrounding the line of scar-tissue between the rectum and bladder. The right ovary and tube were also pinned down to this scar-tissue by numerous vascular adhesions. The attempt to reach the ureter at this point was therefore abandoned, and it was sought out at the pelvic brim, where it was readily found after lifting up the caput coli and incising the peritoneum and pushing aside the fat. It was then traced from the point of crossing the common iliac artery down to the pelvic floor, exposing the whole length of the pelvic portion by splitting the peritoneum over its upper surface. The anterior portion of the ureter was involved in the inflammatory material surrounding the scar, which bled so freely that no attempt was made to dissect it out. Four centimetres of the length of the ureter lying directly posterior to the scar-tissue were dissected out and the ureter lifted up from its bed and divided close to the scar, sacrificing as little as possible of its length. As it was evident that it could not be sutured to the bladder, the latter was dissected free from its attachments to the horizontal rami of the pubis on both sides, with scissors and fingers, and dropped down into the pelvis so as to extend it and carry it more into the back part of the pelvis, gaining at least three centimetres in this way. By this means the ureter and the bladder were easily approximated without strain. A small incision through the bladder-wall, covered with fat at least a centimetre thick, at the point on the right nearest the ureteral end drawn straight across the pelvis, was passed through the peritoneum, being not more than three or four millimetres in length, and just large enough to receive the ureter snugly. The under surface of the ureter was slit up for about four millimetres, enlarging the calibre of its orifice to avoid a stricture, and with a pair of long, delicate forceps, introduced through the urethra, the bladder, and through the incision, the ureteral end was caught and drawn into the bladder and held there while it was being attached to the bladder-wall by about six fine interrupted silk sutures, passed through the muscular tissue of the bladder and peritoneal and muscular coats of the ureter on all sides, beginning with the under side. The ureter, thus dissected out of its bed and attached to

the bladder, was stretched like a lax cord from the posterior part of the pelvis to the bladder, which lay gibbous and flattened out on the pelvic floor. The abdominal incision was closed down to its lower angle, where a narrow gauze drain was inserted for fear of leakage. Care was taken, in closing the incision, not to draw together the peritoneum underlying its lower end, to avoid raising the bladder and indirectly pulling upon the ureter. No leakage occurred and the drain was removed, the wound healing without suppuration, with perfect restoration of continence. At a subsequent cystoscopical examination the abnormally-placed ureteral orifice was found opening into the posterior hemisphere of the bladder, into which it freely discharged its urine.

It has heretofore been necessary, in order to cure a similar trouble, to extirpate the kidney of the affected side. It has not yet been the good fortune of any operator in this country to anastomose the ureter into the bladder at a date subsequent to that of the operation at which the injury was sustained.—*Johns Hopkins Hospital Bulletin*, February, 1895.

PHILADELPHIA COUNTY MEDICAL SOCIETY.

Varicella Complicated by Gangrene of the Scrotum.—DR. C. D. SPIVAK described a case of this kind in a boy of Russian parentage, aged 2 years, in whose family no disease or diathesis was traced. Swelling of the scrotum occurred two days after the first appearance of the eruption upon the face, and gangrene occurred three days later. The penis, the scrotum, and the left inguinal region were much swollen and very tender. The left side of the scrotum was covered by blackish, muddy-looking crusts and detritus covering about two-thirds of it, and passing over the raphé to the right side. The smell was very offensive. The crusts and detritus being carefully removed, the tunica albuginea of the left testicle was exposed to view, thus showing that the gangrenous process destroyed not alone the integument, but also the dartos, the external, cremasteric, and internal fasciæ, and the tunica vaginalis. There was a distinct areola around the ulcer. The existence of pus in the inguinal region was easily demonstrated by its fluctuation, and also by the oozing from a very small spontaneous opening about half an inch from the scrotum. The temperature, 101.6° F. (38.7° C.); pulse, 110. Pressure over the bubo caused pain, but the handling of the ulcer was almost painless. The parts were washed with mercuric-chloride solution and iodoform gauze and bandage applied. On the following day, when the bandage was removed, the ulcer was found to present a somewhat better appearance, but was still angry-looking and covered with pus from the oozing aperture. The child was anæsthetized, the inguinal region laid open throughout its length, and the wound dressed antiseptically.

On the following day the temperature fell to 99.2° F. (37.3° C); the child slept almost the whole night, the first time since it was taken sick; the ulcer and wound were clean and the gangrenous process checked. The same local treatment was continued during the entire period of the regeneration of the scrotum, which took about thirty-five days.

Heredity in Mental Disease.—DR. JOHN B. CHAPIN discussed heredity in its relation to insanity and idiocy, advancing the opinion that physical characteristics are transmitted by inheritance. Knowledge, genius, and culture are not an inheritance, but depend rather on influence, education, and environment. Mental receptivity is transmissible. Psychical qualities are not necessarily an inheritance, requiring favorable surroundings and circumstances for growth and development. Insanity as a disease is not transmissible by inheritance, but may be acquired or evolved from a neurotic heredity as a basis. A neurotic predisposition is transmissible by inheritance, but there is no absolute rule that it will be transmitted in any given case or in any case. In-breeding of neurotic temperaments is most conducive to the creation of neurotic heredity. Idiocy and imbecility may be a defect, having an origin in consanguineous marriages, prenatal conditions, accidents, arrested development, infantile meningitis, tuberculosis, and lack of potency on the part of one of the parents from unexplained causes.—*Philadelphia Polyclinic*, March 23, 1895.

Selections from Reports of Members of the Annual's Staff of Correspondents.

Japan.

DR. W. N. WHITNEY,

CORRESPONDING EDITOR FOR MEDICAL LITERATURE OF JAPAN.

All books, theses, monographs, etc., published in Japan should be sent to

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The Art of Producing Apparent Death and the Art of Resuscitation in Japan.—H. MORINAGA, in an interesting paper, states that Jujutsu, a military art highly esteemed in the feudal ages of Japan, consists in acting on the offensive or defensive without the use of weapons. It is an excellent means of physical exercise, and as such in common practice at the present day by amateurs, students, and many others. It may be divided into five departments: (1) contesting or fighting in order to determine superiority by strength and skill; (2) the formalities observed in such contests; (3) the art of causing apparent death; (4) the art of recalling to life, after such apparent decease; and (5) bone-setting. The most interesting of these are the fourth and fifth departments, in which a practical degree of skill is attainable without the expense of much time and even by a study of the literature of the subject.

Art of Causing Apparent Death.—Despite the difficult nature of this topic, considered as a metaphysical question death may be explained physiologically without much error as the entire suspension of the functions of the respiratory organs, or circulatory system. Such suspension is the direct cause of death; while hunger, strangling, sickness, and many other causes which are thought by common people to be directly responsible are nothing but indirect ones. Yet the suspension of life may not be final and entire,

and patients in such condition may be made to recover by proper means. This death-like state is known to physicians by the name of "apparent death," as distinguished from real death. The department of Jujutsu, which treats of the various ways superinducing this condition, according to certain well-defined rules and methods, is called *Sappo* or *Atemi*, and teaches the art of attacking the body of an opponent in places where the momentary suspension of life may most easily be brought about by simple kicking, thrusting, hitting, or strangling. All these should, however, be practiced according to strict rules, the portions of the body brought into action by those relying upon these arts being as follow: 1. The extremities of the foot (used in kicking). These are divided into the tip of the toe and the front part of the sole. 2. The fist (used in thrusting). 3. The elbow (used in hitting). 4. The knee-pan (used in hitting). 5. The edge of the hand (used in hitting). 6. The forehead (used in hitting or butting). 7. The index finger or middle finger, shaped like the letter V (used in gouging). 8. The two hands (used in strangling).

By skillful employment of these portions of the body a wonderful rôle may be played, offensive as well as defensive. The common and simple means of warding against the attacks to which they lead are, according to circumstances: (1) the parry with the fist; (2) the placing of one's hand on or above the place aimed at; (3) the seizing of the enemy's fist with one hand; (4) the rapid shifting of one's body from side to side; (5) the holding of one's left (or right) arm straight before the breast and then drawing back the body to the right (or left, if the arm be the right); and several others.

The parts especially adapted to attack are as follow: The cerebral suture, the point at which the frontal and two parietal bones come together, and below which the cerebrum lies, so that a strong cerebral shock and instant death may easily result from a blow here; the nasal septum (as the branches of the ophthalmic and other nerves are intertwined in this region, they, as well as other nerves under and around them, may be so excessively disturbed as to cause loss of sensation); the temples; that part below the nose where the trigeminus, portio dura, and other nerves, as well as the superior coronary branch of the facial artery, are situated; behind and a little below the ear, where any forcible blow may cause disturbances in the posterior auricular artery and nerve and the other arteries and nerves lying there, and consequent cessation of life; the base of the throat below the larynx, and to the left and right of this spot; the centre of the median line of the sternum, behind which lie the heart and the lungs; the two points just below the mammary glands, where an assault causes a strong shock to the respiratory and circulatory organs; below the ensiform appendix of the sternum, behind which are the stomach and liver, the nerves and arteries connected with which may be so rudely shaken as to cause instant death; a point beneath the extremity of the twelfth rib on the right side (a blow on this part will shock the liver and gall-bladder, as well as the nerves and arteries connected with them, so greatly as to superinduce a state of stupor or death); a point a little below the end of the twelfth rib on the left-hand side, over the spleen and the stomach; the tendo

Achillis, a blow on which may cause a great shock to the system, unduly exciting the saphenous tibiæ. Besides these parts, blows on the testicles, the wrist, and the foot just above the toes may superinduce instant loss of sensibility.

Art of Restoration in Apparent Death.—The first method consists in standing behind the patient, bringing him to an ordinary sitting posture by raising him beneath the shoulders, and holding him in that position by applying the right knee-pan to the backbone, between the fifth and sixth vertebræ, and placing the hands on the right and left breasts. The index and middle fingers of the hands should be so placed on the breasts as to inclose the ensiform appendix of the sternum and to make their ends reach the mammary glands. Rigidly keeping this attitude, the would-be restorer should draw the unconscious man toward him so that his hands will rise to a little above their former position and the body of the lifeless person be pushed forward a little. At this instant the man will recover his senses. The operator should then, for better and more perfect restoration of the patient, push his hands, still lying on the patient's breast, lightly twice or thrice down to the base of the sternum.

When adopting the second method, the position to be assumed by both the operator and the unconscious man is similar to that of the form just described except that the hands of the operator must be placed on both sides of the chest of the sufferer, somewhat above the lower ribs and under the armpits. The hands thus placed should be pushed a little forward and upward so that the body of the lifeless man will incline outward, when consciousness will return; but for his better restoration the operator should put both hands on his breasts and push them lightly to the base of the sternum, as in the first method.

By the Yeri Kappo method the operator should first seat himself at the right side of the senseless person, and, while grasping the latter's neck with the left hand, which should be kept firmly in this positon to the end, bring the patient to an ordinary sitting posture, and maintain the body in that posture by applying his left knee to the backbone. He should then gently stroke around the centre of the patient's breast, using his right hand for this purpose. When the strokings are finished, the operator should rub the patient's body downward to the abdomen, beginning from the top of the sternum. He should repeat the same movement on both sides of the breast and abdomen; and, as soon as he has finished the rubbings on the left side, he should at once open the fingers and thumbs without removing his hand, so as to form the letter V, the tip of the middle finger being placed over and above that of the forefinger, and then apply the fingers so adjusted on both sides below the belly, holding his right arm and elbow parallel to and between the upper part of the legs of the senseless man. He should then simultaneously push the fingers upward and press the patient's body downward from the neck with his left hand; consciousness will then return.

In practicing the Hainyu So-Kappo method the operator should place the body of the senseless man face upward, the legs being stretched out horizontally. He should then sit astride the lower abdomen and stroke

both sides of the chest with the palm of his right hand, commencing from below and describing a semicircle or parabola in the movement. Having several times repeated this operation, the next step is to push the part below the ensiform appendix of the sternum with the palms of both hands, especially with the balls of the thumbs, with the other fingers outstretched and uplifted.

If the fainting fit be very stubborn the operator should place a wedge of wood or paper between the jaws, so as to prevent the senseless man from biting off the tip of his tongue. He should also place the head a little lower than the body, with the mouth upward, in order to avoid cerebral anæmia. Moreover, he should, for the sake of better treatment and ultimate complete restoration, place the hands of the patient under his head; or, still better, an assistant should move the hands gently back and forth, with a circular sweep, some sixteen or seventeen times.

In the Ura-Katsu method it is necessary for the operator to turn the body of the patient face downward. To do this the operator should, approaching the body from the right hand, seize the neck with his left hand and then pull the body toward himself, so as to bring it to a position facing downward. When so placed, the restorer should sit astride it and stroke the back several times. He should then put the balls of his thumbs on both sides of the fifth lumbar vertebra and push upward. This pushing should be repeated if the patient is not brought back to his senses by the first treatment. A special practical use of this method is possible in the case of drowned persons.

Norway.

DR. F. LEVISON,
REFERENT FOR DEN DANSK LITTERATUR VEDRØRENDE: ALMINDELIG MEDICINSK PATHOLOGI OG THERAPI, DERI INDBEFATTET, NERVE- OG SINDSSYGDOMME, PÆDIATRIK, OBSTETRIK, GYNÆKOLOGI, HYGIEINE, DEMOGRAPHI, RETSMEDICIN, PATHOLOGISK, ANATOMI, BAKTERIOLOGI.

Alle medicinske Böger, Disputatser, Monographier, Tidsskrifter, etc., der adkomme i Danmark bedes sendt til

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Composition of Human Milk.—AXEL JOHANNESEN (*Norsk Mag. f. Lägev.*, p. 1, 1895) has made researches on the milk of twenty-five women from 20 to 46 years of age, in the different periods of lactation, from the first to the thirteenth month after delivery. The specimens of milk were taken from both breasts either before or after the child had nursed, under given dietetic conditions, the food being weighed and measured with exactitude. The total quantity of albumin, casein, and globulin averaged 1.104 per cent., varying but little from this figure; the quantity of fatty matters varied from 0.63 to 6.68 per cent., with an average of 3.21 per cent.; sugar, from 2.55 to 9.77 per cent., the average being 4.67 per cent. The specific gravity of the milk was in inverse proportion to the quantity of fatty matter; analyses made at different hours of the same day often showed a notable difference, especially in the fatty constituents, which were much greater immediately after the child had nursed than before, while the quantity of sugar and albumin remained about the same. In the early months of lactation the amount of albumin was greater than later on. The food exercised a great influence on the milk; an abundant diet caused

it to be rich in albumin and fatty matters, while a preponderance of amylaceous food made it poor in albumin and sugar, but rich in fatty matters.

Subphrenic Pyopneumothorax.—LAACHE (*Norsk Mag. f. Lägev.*, p. 1021, 1894), in a case of this kind with the ordinary symptoms, practiced resection of the eighth rib and found the cavity of the pleura empty. At the end of two days the abscess could be opened, when a large quantity of pus escaped. It was mixed with air, had a fæcal odor, and contained numerous black points which gave the reaction of hæmin. In another case there was perforation of the diaphragm, with empyema. Operation for the latter was followed by the resection of several ribs, and led to considerable improvement in the patient's condition. Complete recovery, however, did not take place, as a fistula persisted, opening at intervals of two or three weeks and giving exit to a varying quantity of pus. The author is of the opinion that a narrow communication must have existed between the abdominal cavity, where the abscess first formed, and the pleural cavity.

THUE, in the same journal (p. 1030) describes a case of subphrenic pyopneumothorax in which the diagnosis was verified by autopsy.

Sweden.

DR. F. EKLUND,
Brefvexlande Medarbetare
för den
SVENSK MEDICINSK LITTERATUR.

Af alla i Sverge utkommande medicinska tidskrifter, bocker, afhandligar, monographier a. s. v. torde ett exemplar benäget öfversändas till

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Stockholm.

Treatment of Trachoma.—U. L. HELLGREN treated forty-two cases, some of trachoma, some of follicular conjunctivitis, according to Knapp's method (*Hygeia*, lvi, No. 12, p. 508). Before the operation he disinfected the conjunctival sac with 1 to 5000 corrosive sublimate, and after the operation washed it out thoroughly with the same solution in a strength of 1 to 1000, as recommended by Bjerrum. He never made use of scarification, and substituted smooth forceps for the cannulated forceps of Knapp. In six cases keratitis followed the operation, being central in one case, and followed by cloudiness of the cornea, so that sight was diminished. He regards operative intervention as contra-indicated in acute trachoma, but not where the disease is accompanied by corneal complications.

Fibrous Stricture of the Rectum.—A case of this kind is reported by LONNBERG (*Hygeia*, lvi, No. 12, p. 548) in a hotel-servant, aged 45 years, a III-para, who had had one difficult delivery, causing rupture of the perineum. She had also suffered from blennorrhagic proctitis following gonorrhœa, and had had chancre and bubo. She was anæmic and for a week previous to operation had shown symptoms of ileus. A complete ring encircled the anus, which was so constricted as to barely admit the first joint of the little finger. The pus from the urethra contained diplococci. There were also fissures of the anus, rendering defecation very painful. The fibrous stricture was extirpated, and was found to include the entire rectal wall, being one centimetre thick and one and one-half centimetres high. Perineorrhaphy according to Tait's method was also performed.

According to Berg, who examined the case, the condition probably originated by inflammation of the Bartholinian gland working its way to the rectum through a fistula, which was observed at the operation.

Operation for Brain-Tumor.—BRUZELIUS and BERG describe the case of a man, aged 58 years, who, within twenty months, had had eleven attacks of fainting with epileptiform convulsions (*Hygeia*, lvi, No. 12, p. 529). After the first of these a severe headache developed, at first limited to the right temple, but gradually spreading and increasing in intensity. After the third attack, aphasia developed, and after the sixth agraphia, followed shortly by alexia, weakness of both extremities, pupillary stasis, and paresis in the inferior portion of the zone of the right facial nerve, with deviation of the tongue to the right. A diagnosis was made of diffuse gliomatous degeneration, with cyst-formation in the inferior portion of the central, anterior, and posterior gyri of the third and probably of the second frontal convolutions. Berg made a vertical incision four centimetres in length, at a point corresponding to the two inferior thirds of the central gyri, finding the brain-substance somewhat resistant, hyperæmic, and discolored, the white substance of the cerebrum being bluish. At a depth of one and one-half centimetres a small cyst was met with, the clear fluid of which was evacuated by puncture. A non-operable circumscribed tumor was found to be present, and the wound closed. The patient's condition improved somewhat for awhile, but ended fatally.

A Rare Case of Stupor, with Forced Feeding for Nine Years.—GADELIUS had an interesting case under his care,—that of a tailor, aged 32 years (*Hygeia*, lvi, No. 10, p. 355), an assiduous workman, slow, taciturn, but amenable to reason. Insanity of persecution developed, the prominent symptoms being anxiety and insomnia, with neglect of his person and refusal to take food. When spoken to he invariably answered, in an undertone, "Fine weather, to-day," and, later on, "I do not know." Forced feeding was carried on uninterruptedly, from April 24, 1883, to February 12, 1892, the body-weight increasing during this period from 46 to 73 kilogrammes (101 to 160 pounds). From April, 1883, to May, 1886, he remained in a condition of complete stupor and anæsthesia. The author considers the prodromic delirium as a quasi-paranoiac psychosis in a degenerate subject, and regards the case as a psychosis of exhaustion, being practically a condition of syncope from beginning to end. On awakening from the stupor the patient had lost most of his former knowledge of things and places, but soon recovered it.

Clinical Notes.

A Case of Dual Brain Action.—This case, described by DR. LEWIS C. BRUCE in the spring number of *Brain*, is that of a Welsh sailor, aged 47 years, admitted to the Derby Borough Asylum for insanity dating back 15 years and beginning with melancholia. He appears to have two separate and distinct states of consciousness, the right and left brain alternately exert-

ing a preponderating influence over the motor functions. In one stage he speaks English, in the other Welsh. When in the English state he shows all the symptoms of chronic mania, is fearless, destructive, fairly intelligent, and recalls incidents of his past life, but is totally oblivious as to what transpires during the Welsh stage. Occasionally, when changing from the Welsh to the English stage, or the reverse, this patient passes through an intermediate condition, in which he is ambidextrous, speaks a mixture of Welsh and English, and understands both languages. This intermediate stage is often absent or so short as to pass unnoticed, the patient suddenly waking up to life and activity or becoming suddenly demented. These sudden changes generally occur after a meal or after a bath. In the Welsh stage his condition is one of dementia. He does not understand English, and talks a gibberish in which some Welsh words can be recognized. He loses desire for food, smell and taste disappear, and the circulation becomes weak, the extremities livid or œdematous, and left-handedness develops.

It would appear that in this case the cerebral hemispheres are capable of individual mental action, and that the mentally-active cerebrum has a preponderating influence over the control of the motor functions, the patient living two separate existences during the two stages through which he passes, the mental impressions received during each of these separate existences being recorded in one cerebral hemisphere only. If this is not so, how can one account for the patient's ignorance of events which have happened to him in the Welsh stage when he passes into the English condition? Or his suspicion and distrust of attendants and doctors, ignorance of familiar and much-coveted objects, as money and tobacco, when in the Welsh stage; whereas, in the English stage, he recognizes and is very friendly with the staff, while the sight of money or tobacco is sufficient to bring him running the length of the ward? A comparison of the mental power of either cerebral hemisphere places the right at a much lower level than the left. Is this due to the unequal ravages of disease or to the unequal development of education?

Judging this case by its own characteristic symptoms, Dr. Bruce inclines to the belief that even in health each cerebrum must have acted independently and received external impressions separately; that, on the advent of mental disease, each cerebral hemisphere still maintained its individuality, the left exhibiting symptoms of mania, the right those of melancholia and that the disease has advanced more rapidly in the right brain, which now exhibits symptoms of dementia. Or, he suggests, only one lobe of the cerebrum, the left, is educated, and takes the greater part in mentalization; the right half, though functionally active with regard to motion, sensation, and the lower reflexes, has little education or power of mental action except that which it derives from inheritance; the centres in connection with sight, smell, taste, and hearing are equally developed in both hemispheres, but only one side, the educated one, is able to translate, analyze, and mentally appreciate the crude sensations received.

Antitoxic Treatment of Diphtheria.—A series of thirteen cases of diphtheria treated by antitoxin at the University College Hospital at London,

under the care of Dr. Frederick Roberts, confirms the opinion that the remedy is one of considerable efficacy (*Lancet*, April 13, 1895). The cases, being all treated in hospital and the diagnosis in each controlled by the bacteriological test, were observed under conditions favorable to the formation of a just appreciation of their character and of the influence of antitoxin upon them. In six out of the thirteen cases tracheotomy became necessary, only one of these tracheotomized subjects succumbing. Death from suppression of urine occurred after seven weeks' illness in a case of pharyngeal diphtheria, a clue to this exceptional course being probably afforded by the fact that one of the kidneys was atrophied and cystic. It is also suggested that the defective renal elimination in this case had some relation to the roseolous rash which appeared on the skin during treatment. In his remarks on these cases it will be seen that Mr. Bunch, house-physician, notes that a rash appeared in three cases, accompanied by a rise in temperature. His suggestion as to the possibility of the fluid containing some impurity is one deserving of the most careful scrutiny.

Excision of the Tonsils.—Dr. Arthur Ames Bliss discusses this subject in the *Therapeutic Gazette* for March, calling attention to a type of hypertrophied and diseased tonsil in which the tonsillotome cannot surround the mass to be excised, but simply presses against the free surface. A certain amount of the tissue may engage in the ring; but even where the free, projecting mass of the tonsil can be planed away more completely, the parts shielded by the faucial pillars remain still to annoy the patient by inflammatory attacks, while the pressure exerted upon the soft palate and pharyngeal wall is scarcely, if at all, relieved. The cold snare is more effectual, but the lateral masses escape its grasp, being protected by the adherent faucial pillars or the capsule which covers the tonsil in such cases. Not infrequently the anterior pillar of the fauces has become a thick, broad, fibrous band, which completely envelops the anterior half of the tonsil, and, by a process, apparently of contraction, has pressed and rotated the gland backward, so that whatever may remain of its free surface presents toward the posterior wall of the pharynx. Such type of tonsil is most active in its tendency to take on inflammatory processes and to produce constant irritation, which affects the neighboring parts of the respiratory tract. The tonsillotome and snare are here quite useless. The process of destruction by electro-cautery puncture is very slow, tedious, and painful, and it is not rare for attacks of general tonsillitis to arise during the course of this method and to interrupt its continuance. Dr. Bliss has had the best results from the use of a scissors adapted from Teet's nasal cutting forceps, in conjunction with Farnham's crocodile-jaw forceps. The special features of the scissors are its long, powerful handles; the relatively-short, strong blades, and a socket into which the shank of the lower blade falls as the scissors closes. This socket arrangement presses the blades together and prevents them from being sprung apart when cutting through thickened tissue. The two instruments—forceps and scissors—readily serve as a tongue-depressor while the operator is at work, but in trimming out tonsils under cocaine the patient can, of course, assist by holding the tongue-depressor himself,

when one is required. The tonsil-tissue is grasped firmly by the jaws of the forceps, which will not slip away or tear out, as the volsella so often does. The scissors are then passed beneath the parts thus raised and pieces of varying size, measured precisely as the operator desires, are thus trimmed away. Portions of the growth lying hidden beneath the anterior pillar of the fauces can be pulled out and excised with precision, thoroughness, and care. Upon adults this can be done without ether, a 5-per-cent. solution of cocaine, applied on pledgets, being sufficient to cause local anæsthesia. He has frequently been able to use this method with quite young children, but, where post-nasal adenoids exist, he completes the post-nasal and faucial operation at the same time under ether. In employing the tonsil-scissors, it is necessary to hold them in the hand nearest to the tonsil to be operated upon; for instance, the operator's right hand when excising the left tonsil of a patient. He has never had a dangerous hæmorrhage or even an alarming one following the use of this method; and, from an examination of the ANNUAL OF THE UNIVERSAL MEDICAL SCIENCES for six years, he concludes that hæmorrhage is an unusual complication.

Dr. Bliss has found it advantageous to use a position in operations under ether which he has not seen described. The patient, having been etherized in the recumbent position, is carefully raised by the trained assistant to a sitting posture. The assistant, standing close by the right side of the couch or table and resting his weight upon his right foot, places his left knee upon the couch, pressing the knee and leg firmly against the sacrum and back of the patient, who thus rests against the assistant's leg, abdomen, and chest. Thus the assistant has firm support, while he is enabled to hold the patient securely, giving by his own body firmness and easy movement to the otherwise limp and relaxed patient; he can also hold the mouth-gag in position with one hand, while the other is free to support the patient's head or chest, or to hold napkins with ether, during the short intervals when etherization can be maintained. By flexing his own body forward on his thighs, he can also, when necessary, throw the patient's body well forward, so as to favor the free escape of blood from the mouth or nares. At the same time it gives him power, simply by sinking back into a sitting position himself, instantly to bring the patient into a recumbent position at a moment's warning. Dr. Bliss would not use the position in chloroform anæsthesia, in cases of serious cardiac or arterial disease, or in the aged.

Treatment of Uric-Acid Gravel.—DR. VAUGHAN HARLEY, of London (*British Medical Journal*, March 23, 1895), holds that the treatment of uric-acid gravel should take two directions, according as we desire to increase the solubility or decrease the amount of uric acid formed. It is well to remember that in the majority of cases uric-acid deposits are due to an increased tendency to precipitation, and not to excessive formation of uric acid.

In cases due to the former condition, we should give drugs which help to hold uric acid in solution. In spite of the recent outcry against piperazine, he has found it of great service. It appears to have no action whatever on the quantity of uric acid daily formed in the organism, but merely on its solu-

bility. On this account he always gives it in such cases in combination with alkalies, either in the shape of alkaline waters or potash bicarbonate combined with iodides. As the urine is naturally most acid at night and in the early morning, and therefore most likely to deposit uric acid at those periods, the alkalies should be given at bed-time. The diet in these cases is not of so much importance, except that salines and vegetables should be preferred. In cases where the uric-acid deposit is due to excessive formation, a carbohydrate diet is the most useful. Starch, sugar, and vegetables should, therefore, be the staple diet, and meat and fish only be used in small amounts. The old idea, that sugar causes an increase of uric acid, has no foundation, as he has found, in a series of experiments performed on himself, as much as a quarter or even a pound of sugar a day not causing any noticeable increase in the uric acid passed. Alcohol, on the other hand, should be prohibited, as it causes an increase in the quantity of uric acid voided. Quinine and arsenic decrease the quantity because they diminish the quantity of leucocytes, and, therefore, in cases where gravel is due to an excessive formation of uric acid these drugs are most valuable. While moderate muscular exercise is of service, excessive exercise is, on the other hand, harmful. Although alkalies are here of some assistance, they, like piperazine, are only of secondary importance by increasing the solubility of the uric acid formed.

A New Method of Fixing the Sigmoid in Inguinal Colotomy.—Mr. Leonard A. Bidwell, of the West London Hospital, suggests, in all cases where a permanent artificial anus is required, the following method, by which a bridge of normal skin separates the openings into the upper and lower portions of the sigmoid, so that there is no chance of any fæces finding their way into the rectum. The incision being made in the ordinary position, the peritoneum is stitched to the skin, a loop of sigmoid is brought out of the wound, and a good-sized hole scratched in its mesosigmoid. A silk-worm-gut suture is passed through the whole thickness of one edge of the wound; it is then carried across the wound through the hole in the mesosigmoid, and is finally passed through the whole thickness of the other edge of the wound. When the suture is tied, the two edges of the wound are united within the hole of the mesosigmoid. This stitch should be inserted at the junction of the middle and lower thirds of the incision. No other sutures are necessary; but, as after the gut is divided it is desirable to stitch the four corners of the upper portion to the skin so as to keep the opening free, he usually passes two sutures through the skin on each side of the incision and leaves their ends untied, so as to avoid having to give chloroform when the gut is divided. On the fourth day the bowel is completely divided on a director passed beneath it, and the sutures, previously passed through the skin, are inserted into the upper end of the gut and are tied. The stitches are removed on the eighth or ninth day. He does not give an anæsthetic when completing the operation, since the section of the gut does not appear to be painful; traction on the bowel, on the other hand, usually gives rise to a good deal of pain. The cases on which he has operated after this method have been very satisfactory.

Nosophen.—SIEFERT (*Wien. klin. Woch.*, March 21, 1895) gives the results of a trial of nosophen, or tetraiodide of phenolphthalein, which contains 60 per cent. of iodine, is soluble in alkalies (in which it remains unchanged), slightly soluble in alcohol, and insoluble in water and acids. It is valuable for insufflation in the after-treatment of galvano-cautery operations in the nose and naso-pharynx, having no taste and odor, and being non-toxic. He found it more effective in rhinitis than other remedies, as it seemed to heal the inflammation and lessen the secretion more rapidly. He also used it as a powder in some cases of venereal disease, with good results.

Neurodin.—This analgesic, introduced in 1893 by von Mering, was tried by UGO LIPPI (*Il Policlinico*, February 15, 1895) in fourteen cases of neuralgia and pains of various kinds. He used doses of 0.5 to 3 grammes (7¾ to 46 grains), and found that these could be repeated several times daily without causing any untoward effect except occasional diarrhœa and, in rare instances, a lessening in the number of heart-beats. It was effective in soothing pain, whether due to neuralgia or to some organic affection; but he states that the analgesic action is not so strong as that of other similar remedies, while the fact that it is not readily soluble in ordinary vehicles renders it inconvenient for general use.

Recent Suggestions in Therapeutics.

Bronchial Asthma.—*Citrate of caffeine*, 5 grains (0.32 gramme), in cachet, or dissolved in water every four hours until bronchial spasm is relieved, after which give at longer intervals, to prevent relapse. If attack come on fairly regularly in the early morning, give 5 or 10 grains (0.32 or 0.65 gramme) at bed-time, repeating if necessary in the morning, as often as indicated. (E. M. SKERRITT, *Practitioner*, April, 1895.)

Bubo—Fontan's Method.—Wash and disinfect region carefully with *Van Swieten's fluid*, diluted with hot water, and using soap if necessary. Make an incision, at the point of fluctuation, with a lancet if the skin is thin, with a straight bistoury if the pus is deep. Evacuate the bubo completely; wash out the cavity with *sublimate solution*, 1 to 1000, leaving this for several seconds in contact with the walls. If hæmorrhage follow the pressure necessary to completely remove the contents, apply a tampon soaked in cold *sublimate solution*, exercising pressure for several minutes. When hæmorrhage has ceased, wash out cavity again with *sublimate*. Inject sufficient of a 1 to 10 mixture of *iodoform* and *vaselin*, liquefied by placing the vessel containing it in hot water at 50° C. (122° F.), to fill, but not distend, the cavity of bubo. Apply immediately a compress of cotton dipped in cold *Van Swieten's fluid*. Pain disappears from the first day, and cure is complete in from six to seven days. (RULLIER, *Jour. de méd. et de chir. prat.*, April 10, 1895.)

Burns.—Never allow lint or cotton to come in contact with the burnt surface. Place between two layers of gauze a thin layer of cotton soaked in the following: ℞ *Carbolic acid*, 4 drachms (16 grammes); *olive-oil, saturated solution (aqueous) borax*, each, 8 fluidounces (250 grammes). M. Shake well. Envelop the burnt surface, and over this spread a layer of cotton-batting, which is slow to absorb and prevents evaporation; finish with a roller bandage. Leave this dressing until the third day; then remove and irrigate the burn from one-half to one hour with an antiseptic solution as hot as can be borne. Dry thoroughly with baked cloths and apply: ℞ *Carbolic acid*, ½ drachm (2 grammes); *boric acid*, 1 drachm (4 grammes); *bismuth subnit.*, 2 drachms (8 grammes); *petrolatum*, q. s. ad 1 ounce (30 grammes). M. Spread on linen and finish as in primary dressing. Renew dressing daily. Continue the hot wash until all the sloughs separate, then discard it. (DIAL, *Louisville Medical Monthly*, March, 1895.)

In Severe Cases due to Burning Clothing.—Lint soaked in warm *carbolized carron-oil*, with a thick envelope of cotton-wool, is, perhaps, the best application for the first week; but the nauseous smell of the linseed-oil, combined with the fœtor of purulent discharge, is horribly offensive and helps to keep up the tendency to diarrhœa common at this period and frequently attributed to duodenal ulcer. Use the following alternative treatment: Dress the vast, beef-red, profusely-suppurating wounds with *gall ointment* thickly spread on strips of lint, or with *ointment* of *galls* and *opium*, or *boric ointment* having about 1 drachm (4 grammes) of finely-powdered *galls* to the ounce (30 grammes); wrap thickly in cotton-wool and bandage firmly, not loosely. Improvement is rapid, the smell diminished, and the sufferer finds the treatment comforting. (S. GROSE, *Lancet*, March 23, 1895.)

Chordee.—If necessary to give *opium*, use the following: ℞ *Pulv. opii*, 6 grains (0.39 gramme); *pulv. camphoræ*, 18 grains (1.17 grammes); *ol. theobromæ*, q. s. M. Fiant suppositoria vi. Sig.: Use one at bedtime. (KEEN, *Coll. and Clin. Record*, March, 1895.)

Diphtheria.— ℞ *Liq. ferri subsulphatis*, 2 fluidrachms (8 grammes); *phenol*, 1 drachm (4 grammes); *aquæ*, ½ fluidrachm (2 grammes); *ol. sassafrasæ*, 1 drachm (4 grammes); *glycerinæ*, 4 fluidrachms (16 grammes). Sig.: Apply to the growth in throat by means of a swab every three or four hours. In recent cases membranes will separate in about thirty-six hours. In very severe cases it is sometimes necessary to continue its use three or four days. After three or four applications and the internal administration of the following preparation for about twelve hours, diphtheria ceases to be infectious: ℞ *Zinci sulphatis*, 6 grains (0.40 gramme); *phenol*, 9 minims (0.58 gramme); *aquæ*, 2 fluidounces (60 grammes); *ol. sassafrasæ*, 12 minims (0.78 gramme); *tr. digitalis*, 1½ fluidrachms (6 grammes); *glycerinæ*, q. s. ad 6 fluidounces (186 grammes). M. Sig.: One teaspoonful every hour, or in severe cases, in patients over 12 years of age, one teaspoonful every half-hour. Do not continue longer than

Diphtheria (*continued*).

thirty-six hours, but change to following tonic: ℞ *Potass. chloratis*, 1 drachm (4 grammes); *tr. ferri chloridi*, 1 fluidrachm (4 grammes); *glycerinæ* 2 fluidrachms (8 grammes); *aquæ*, q. s. ad 4 fluidounces (124 grammes). M. Sig.: Teaspoonful every four hours, followed in ten minutes by a little nourishment. Cure will occur in a majority of cases within seventy-two hours. Has never failed author during past sixteen years. Where growth has extended into larynx, use following formula in connection with the others: ℞ *Zinci sulphatis*, 10 grains (0.65 gramme); *phenol*, 15 minims (1 gramme); *aquæ*, 1 fluidounce (31 grammes); *eucalyptol*, 20 minims (1.3 grammes); *thymol*, 10 grains (0.65 gramme); *menthol*, 5 grains (0.32 gramme); *ol. sassafrasæ*, 20 minims (1.3 grammes); *alcohol*, *glycerinæ*, of each, q. s. ad 4 fluidounces (124 grammes). M. Sig.: Use with atomizer every hour, placing child on its back and inserting atomizer-tube well back on tongue. For first applications dilute with water. (CALLENDER, *Therapeutic Gazette*, February 15, 1895.)

Dry Eczema with Pruritus.—*Menthol*, 2 grammes (31 grains); *resorcin*, 1 gramme (15½ grains); *precipitated sulphur*, 10 grammes (2½ drachms); *zinc oxide*, 15 grammes (3¾ drachms); *vaselin*, 30 grammes (1 ounce). (THIBIERGE, *Thérapeutique des maladies de la peau*, Paris.)

Eczema with Moderate Desquamation.—*Salicylic acid*, *resorcin*, and *balsam of Peru*, of each 1 gramme (15½ grains); *precipitated sulphur*, 5 to 10 grammes (1¼ to 2½ drachms); *vaselin* and *lard*, each 50 grammes (1½ ounces.) (THIBIERGE, *Thérapeutique des maladies de la peau*, Paris.)

Food for Infants.—When predigestion of food is to be combined with sterilizing, as is very often necessary in cases of illness, employ the following formula for a sterilized peptonized *milk* mixture: ℞ *Water*, 8 ounces (250 grammes); one-half of a peptonizing tube or one peptonizing tablet. Dissolve. Add *milk*, 8 ounces (250 grammes). Peptonize. Then use: *Peptonized milk*, 2 ounces, (62 grammes); *cream*, 1½ to 2 ounces (46.5 to 62 grammes); *milk-sugar*, 1 measure; *water*, enough to make 8 ounces (250 grammes). Sterilize by placing over brisk, but not too hot, fire for forty-five minutes, removing hood of sterilizer and leaving lid slightly ajar. Temperature of milk does not go above 90° C. (194° F.), its digestibility thus not being affected. Safe for use for twenty-four hours. (J. P. CROZER GRIFFITH, *University Medical Magazine*, April, 1895.)

Leucorrhœa.—*Tincture of cantharides*, 96 minims (6.25 grammes); *tincture of ferric chloride*, 160 minims (10.65 grammes); *diluted phosphoric acid*, 160 minims (10.65 grammes); *syrup of lemon*, 2 fluidounces (62 grammes); *water*, sufficient to make 4 fluidounces (124 grammes). Mix. Dose: One teaspoonful, in water, after meals. Useful in cases where examination is not practicable. If treatment do not succeed, something more than simple hyperæmia or mild inflammation may be suspected. (SLOCUM, *Philadelphia Polyclinic*, March 9, 1895.)

Pruritus Vulvæ of Menopause.—*Morphine sulphate*, 6 grains (0.39 gramme); *boric acid*, 1½ drachms (6 grammes); *camphor-water*, 6 fluidounces (186 grammes). Mix. Label: Poison. Apply to the affected parts after ablution with warm water and Castile soap. (B. F. BAER, *Philadelphia Polyclinic*, March 30, 1895.)

Severe Heart-Pain after Influenza.—Enjoin rest and give hypodermatic injection of *morphine*, ¼ to ⅓ grain (0.015 to 0.02 gramme) at the maximum point of suffering, preceding by following draught: *Spirits of ether*, *compound spirits of ammonia*, *tincture of sumbul*, each, ½ drachm (2 grammes); *camphor-water*, ½ ounce (16 grammes). Repeat draught one hour after hypodermatic injection. When pain is mitigated, give *quinine* in 5-grain (0.32 gramme) doses, dissolved in 20 minims (1.3 grammes) of *dilute hydrobromic acid*, half an hour before usual period of onset, repeated at hourly intervals during painful phase, until three or four doses have been taken. Discontinue for a few days, and when severity of pain is broken give one 5-grain (0.32 gramme) dose every two or three days. If more continuous treatment be necessary in early stage of pain, give *bromide of sodium*, dissolved and sufficiently diluted in 20-grain (1.3 grammes) doses, with 3 minims of *Fowler's solution*, three times daily, after meals. Substitute alkaline carbonates in two or three weeks, with small doses of arsenic. (A. E. SANSOM, *Practitioner*, April, 1895.)

New Books Received.

The editor acknowledges, with thanks, the receipt of the following books:—

RECHERCHES CLINIQUES ET THÉRAPEUTIQUES SUR L'ÉPILEPSIE, L'HYSTÉRIE, L'IDIOTIE, ET L'HYDROCÉPHALIE; COMPTE RENDU DU SERVICE DES ENFANTS, IDIOTS, ÉPILEPTIQUES, ET ARRIÈRES DE BICETRE PENDANT L'ANNÉE 1893. Par *Bourneville*, avec la collaboration de MM. *Boncourt*, *Cornet*, *Lenoir*, *Jules Noir*, et *P. Sollier*. Vol. xiv, 1894. A beautiful volume of lxiv–884 pages, with 89 Illustrations and a Plan of the Hospital. Published by the Editors of the *Progrès Médical*, Paris, 14 rue des Carmes. Price (in paper), 7 francs.

RAPPORTS ET MÉMOIRES SUR LE SAUVAGE DE L'AVEYRON, L'IDIOTIE, ET LA SURDI-MUTITÉ. Par *Itard*, avec un appréciation de ces rapports par *Delasiauve*. Éloge d'Itard par *Bousquet*. Préface par *Bourneville*. 1894. An octavo volume of 200 pages with a Portrait of the Savage. Published by the Editors of the *Progrès Médical*, Paris, 14 rue des Carmes. Price (in paper), 4 francs.

DE LA PUBERTÉ DANS L'HÉMIPLÉGIE SPASMODIQUE INFANTILE. Notes et Observations par le *Dr. H. Leblais*. 1895. An octavo volume of 83 pages. Published by the Editors of the *Progrès Médical*, Paris, 14 rue des Carmes. Price (in paper), 2.50 francs.

RAPPORT ET MÉMOIRES SUR L'EDUCATION DES ENFANTS NORMAUX ET ANORMAUX. Par *E. Séguin*. Préface par *Bourneville*. 1895. An octavo volume of xlviii–380 pages. Published by the Editors of the *Progrès Médical*, Paris, 14 rue des Carmes. Price (in paper), 5 francs.

THERAPEUTIC SUGGESTIONS IN PSYCHOPATHIA SEXUALIS (PATHOLOGICAL MANIFESTATIONS OF THE SEXUAL SENSE) WITH ESPECIAL REFERENCE TO CONTRARY SEXUAL INSTINCT. By *Dr. A. von Schrenck-Notzing*, Practicing Physician in Munich. Authorized Translation from the German by *Charles Gilbert Chaddock, M.D.*, Professor of Diseases of the Nervous System, Marion-Sims College of Medicine; Member of the American Medico-Psychological Association; Attending Neurologist to the Rebekah Hospital; Member of the St. Louis Medical Society; Fellow of the Chicago Academy of Medicine; Corresponding Member of the Detroit Academy of Medicine. Published by The F. A. Davis Company, Philadelphia. London, F. J. Rebman, 1895.

Monographs Received.

The editor acknowledges, with thanks, the receipt of the following monographs:—

Illumination and Examination of the Anterior and Posterior Nasal Cavities, by **D. Braden Kyle**, Philadelphia, 1894.——Cholera, its Prevention and Treatment: Typhoid Fever, its Treatment, by **Elmer Lee**, Chicago, 1894.——The Uric-Acid Diathesis and its Treatment, by **John F. Barbour**, Louisville, 1894.——Fish-Bones in Throat and what they Suggest Concerning Deglutition, by **Adolph Rupp**, New York, 1894.——Sur la Cure Radicale des Hernies, by **Just Lucas-Championniere**, Paris, 1894.——Abstract of two Articles Treating of Progress in Midwifery, by **Hunter Robb**, Baltimore, 1894.——The Limitations of the Use of the Pessary, by **Hunter Robb**, Baltimore, 1894.——Sperminum-Poehl in Chemischer, Physiologischer, and Therapeutischer Beziehung, by **G. Bubis**, St. Petersburg, 1894.——The Diagnosis of Mitral Valvulitis, with a Report of Three Cases, by **Judson Daland**, Philadelphia, 1894.——In Memoriam John M. Keating, M.D., LL.D., by **Judson Daland**, Philadelphia, 1894.——Incipient Inflammations of the Ear in Early Life and their Sequelæ, by **S. MacCuen Smith**, Philadelphia, 1894.——Internal Hæmorrhoids, by **Eugene F. Hoyt**, New York, 1894.——The Complete Method of Operation in Cases of Cancer of the Breast, by **A. C. Bernays**, St. Louis, 1895.——A Case of Sarcoma of the Palate Successfully Treated with the Toxins of Erysipelas, by **Walter B. Johnson**, Paterson, 1894.——Amblyopia from Suppression of the Visual Image, by **Walter B. Johnson**, Paterson, 1894.——Foreign Bodies in the Orbital Cavity, by **Walter B. Johnson**, Paterson, 1894.——Primary Melanotic Sarcoma of the Eyelid, with Report of a Case, by **M. W. Zimmerman**, Philadelphia, 1894.——Radical Cure of Hernia, with One Hundred Tabulated Cases, by **John B. Deaver**, Philadelphia, 1895.——The Indications and Nature of Treatment in Severe Abdominal Injuries and Intra-abdominal Hæmorrhages Unaccompanied by External Evidence of Violence, by **John B. Deaver**, Philadelphia, 1895.

☞ ***Any journals, exchanges, reprints, monographs, or books not sent directly to the editorial office, 28 rue de Madrid, Paris, will not receive attention either in the "Annual" or the "Universal Medical Journal."***

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OF THE

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CHARLES E. SAJOUS, M.D., EDITOR-IN-CHIEF,

28 RUE DE MADRID, PARIS, FRANCE.

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(End of Editorial Department of Journal for May, 1895.)

The Uses of Aristol.

Among the agents for the treatment of wounds which modern synthetic chemistry has placed at the disposal of the physician, Aristol can justly lay claim to a prominent position. Aside from its employment as a wound-dressing, it has been extensively utilized in affections of the skin, in diseases of the nose and throat, in ophthalmology, otology, etc. The *British Medical Journal*, March 9, 1895, contains an abstract of an article by Gevaert (*Flandre Médicales*, February 21, 1895), in which this author gives his experience of the use of Aristol. He says:—

"Aristol, which is an iodine derivative of thymol, is a reddish, inodorous powder, insoluble in water and glycerin, little soluble in alcohol, but soluble in ether and fatty oils. It has been used with success by Eichhoff in cases of psoriasis, lupus, parasitic cutaneous affections, and tertiary ulcerations. In lupus it is said to have given good results, and to have a specific action on tubercle bacillus. Ethereal solutions of 10 per cent. sterilize all cultures of microbes excepting the anthrax bacillus and the micrococcus tetragenus. Its insolubility renders its use limited to the same extent as iodoform, over which it has the advantage of producing no toxic effects." Gevaert has used it with good effect in lupus combined with curetting, and quotes a severe case which he treated in this way, which healed in five weeks, and has remained healed ten years afterward. He also recommends it in suppurating bony cavities. In cases of otorrhœa with small perforations it is dangerous from the liability to block up the perforation and cause accumulation of pus in the middle ear. It is also recommended in burns.

Hot Springs, Arkansas. Solid Train Through from St. Louis.

Since Sunday, February 17th, the Iron Mountain Route runs a solid train through from St. Louis to Hot Springs, consisting of vestibule sleeping-cars, reclining-chair cars (seats free), and baggage-cars, leaving Grand Union Station 8.35 P.M. daily, arriving at Hot Springs 12.30 noon next day. The climate at this famous resort is mild and invigorating, coming as it does from the pine-clad mountains surrounding the "Valley of Vapors." The three grand hotels, accommodating two thousand people, are villages in themselves, music being furnished in the rotunda, as well as many other attractive features, such as dancing, progressive euchre, etc. The donkey-parties, horseback-riding, and drives to the many adjacent springs and resorts in the mountains are well patronized and very enjoyable, as the roads are fine and the scenery beautiful. Descriptive and illustrated pamphlets furnished free on application to Company's Agents or H. C. Townsend, General Passenger Agent, St. Louis.

Glycero-Phosphates.

A dose of Glycero-Phosphate of Lime is 15 to 45 grains per day for adults. Glycero-Phosphate of Lime and Glycero-Phosphate of Iron in combination have given excellent results in the treatment of scrofula in children. The calcium salt is especially indicated for the administration by mouth, while the sodium and potassium salts, which are of a syrupy consistency, are more readily soluble, and therefore better for hypodermatic injections. The watery solutions of all the Glycero-Phosphates are not staple, but decompose in a short time.

THE

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Selections from Society Proceedings.

FRANCE.

SOCIÉTÉ FRANÇAISE D'OPHTALMOLOGIE.

Iritis of Nasal Origin.—M. FAGE, of Amiens, stated that, since Ziem had shown the relation existing between nasal affections and certain forms of iritis, he had not seen a case recorded in which ozæna had caused the disease. He had observed such a case in a man of 22 years who presented no other cause for the ocular infection. In the beginning of January iritis developed in the left eye, followed by symptoms of irido-choroiditis in the right eye. There was atrophic rhinitis, and the nasal mucus showed the bacillus of Lœwenberg in almost pure cultures. It was also found in the conjunctival *cul-de-sac*, but attempts to discover it in the blood and in the anterior chamber gave negative results; however, the eye of a rabbit inoculated with the needle used in the paracentesis showed a slight infection. The sinuses were transparent. By the end of April the left eye had healed, with the exception of an exudate which persisted in the anterior chamber; the right eye remained inflamed, with a notable disturbance of the aqueous humor and alterations of the vitreous. These lesions, according to Dr. Fage, must be attributed to infection by the microbe of ozæna, which is capable of producing infection at a distance, provided it gains access to the blood-vessels or lymph-glands.

M. E. BERGER had observed an iritis and an otitis media on the right side due to purulent rhinitis on the same side from retention of the nasal secretion, the right nasal fossa being obstructed by a naso-pharyngeal tumor. Partial extirpation of the tumor caused improvement in the otitis and iritis, and its further growth caused an aggravation of both affections, which were only cured by its total extirpation. The danger of ozæna as

regards the organs of sight is as yet but little understood. Terson and Gabrielides found the coccobacillus of Lœwenberg in the lachrymal sac in patients with ozæna without alteration of the conjunctiva; but, on the other hand, in several cases observed by M. Berger in which there were grave ocular affections, this bacillus was absent from the lachrymal sac examined by M. Lœwenberg. These latter cases must be explained by an increased virulence of pyogenic bacilli in ozæna patients or by the action of the toxins of its bacillus. He attributes to the toxins a case of central scotoma in a woman of 32 years, in whom the treatment of ozæna led to an improvement of vision.

M. Mazet, of Bordeaux, found that the characteristics of Lœwenberg's bacillus were not sufficiently pronounced to differentiate it from Friedländer's bacillus. There are always other micro-organisms present in cases of ozæna that may be the cause of the ocular infection, and the case of M. Fage does not therefore prove that the iritis was due purely to ozæna.

Treatment of Detachment of the Retina.—M. Terson, of Toulouse, discussed the value of electrolysis in the treatment of detached retina, and stated that the positive pole should be used to penetrate the eye in order to insure rapid occlusion of the wound and prevent the escape of the vitreous. The electrodes should be proof against the attacks of the products of electrolysis and sufficiently rigid to penetrate the sclerotic. The intensity of the current should be measured by a very sensitive, but non-oscillating, galvanometer. He uses a constant current of 5 milliampères for one minute. Since July, 1894, he has thus treated 17 cases of retinal detachment; 5 of these were too recent to be taken into account, 1 case of three years' standing was aggravated, 2 showed negative results, 3 temporary improvement, 5 encouraging improvement, and 1 immediate cure, maintained up to the time of report (nine months) and attributable only to the treatment. Positive electrolysis, in his opinion, is applicable to recent cases, and, the sooner it is employed, the greater the chances of recovery. Its use does not preclude the employment of medical treatment, necessary in diathetic cases, the palliative value of which has been shown by long experience.

M. Dor, of Lyons, reported remarkable results obtained by him during the past year by combining the leeches of Heurteloup with three or four galvano-cautery points applied to the surface of the detached retina. The applications are made twice and, later, once a week.

M. Dianoux, of Nantes, has had good results from the subconjunctival injection of 1 cubic centimetre of chloride of sodium at the point of detachment.

M. Abadie, of Paris, having tried several simultaneous electrolytic punctures without advantage, prefers to make a second puncture in several days when no result has been observed from the first.

M. Parinaud, of Paris, regards posterior sclerotomy as the best and most harmless treatment of retinal detachment.

M. Boucheron, of Paris, believed that, as the principal object was to gain time, recent cases should be treated surgically, the operation chosen

with a view of decreasing ocular tension on the exterior surface of the retina and increasing it on the interior surface.

ACADÉMIE DE MÉDECINE.

Latent Tuberculosis of the Tonsils.—PROFESSOR DIEULAFOY called attention to a torpid variety of pharyngeal tuberculosis the favorite seat of which is the adenoid tissue of the naso-pharynx. This tuberculosis manifests its presence by an exuberant growth of the lymphoid organs of that region,—in other words, by hypertrophy of one or more of the palatine and pharyngeal tonsils. This view would, if confirmed, lead us to regard hypertrophy of the tonsils and adenoid growths as, in many instances, cases of tuberculous overgrowth of adenoid tissue. He bases this belief on the results of inoculations into guinea-pigs of fragments of enlarged tonsils and adenoid vegetations. Of 60 animals thus inoculated with tonsil tissue, 8, or 13 per cent., succumbed to generalized tuberculosis; while, of 35 inoculated with adenoid tissue, 7, or 20 per cent., became tuberculous. In all the persons who furnished the material for inoculation (enlarged tonsils and adenoid growths) the pharyngeal tuberculosis was primary, and not consecutive to the pulmonary variety. It is to be supposed that young subjects with enlarged tonsils, etc., provide a favorable soil for the growth of the bacillus of Koch, which finds access to the adenoid culture-medium either with the food (milk, especially) or with the air respired (sojourn in a bacillary atmosphere). Professor Strauss, of Paris, has, indeed, demonstrated the presence of virulent tubercle bacilli in the nasal cavities of individuals habitually breathing the same air as phthisical patients. An open wound is not necessary for penetration, since the bacilli can find an entrance through the epithelium. In some instances the bacilli present in the adenoid tissue are, after a sojourn of months or years, destroyed by phagocytosis, which determines an indurating, fibrous process in the tonsil. In other cases, however, the bacillus finds its way into the lymphatic vessels, and enlarged submaxillary and cervical glands are the result. Lymphatic infection is often started by the occurrence of measles, scarlet fever, whooping-cough, etc. This glandular tuberculosis may, in its turn, remain local and finally end in recovery; but in other instances rapid generalization may result. The third stage of tonsillitic tuberculosis is the spread of the process to the lungs, the bacillus reaching those organs from the cervical glands *via* the lymphatics, thoracic duct, and the right heart.

M. CHAUVEAU stated that, in animals fed on tuberculous matter, infection may take place by inoculation of the adenoid tissue of the base of the tongue and the isthmus of the pharynx, this inoculation being proved by the swelling of the cervical and submaxillary glands. Sometimes a minute erosion explains their inoculation, but often the surface is found intact.—*Lancet*, May 11, 1895.

Treatment of Appendicular Colic and Appendicitis.—M. LÉON JOUBERT, of Mont Dauphin (Hautes-Alpes), in a paper on this subject gave the details of three consecutive cases of cure by rectal injections of glycerin in

large doses. He is firmly convinced that this remedy should be employed in every case before attempting laparotomy,—an operation less dangerous, it is true, in these days of antisepsis, but often impracticable in the country, in the colonies, or at small military camps, where the physician finds himself without assistants or without the necessary armamentarium.

SOCIÉTÉ DE BIOLOGIE.

Serum Treatment of Puerperal Fever and Erysipelas.—M. ROGER related some cases of puerperal fever and erysipelas treated by the injection of an antistreptococcic serum. The first case, a severe one, was cured in forty-eight hours. The next case, treated by himself and CHARRIN, was that of a woman who was delivered on February 18th. The next day fever appeared, and on the evening of February 22d the temperature was 102.2° F. (39° C.). On the morning of February 23d the temperature was 101° F. (38.3° C.), lochia fetid; 26 cubic centimetres (6¾ fluidrachms) of the serum was injected. In the evening, the temperature having risen nearly one degree, another injection of 20 cubic centimetres (5 fluidrachms) was made. Next morning the patient felt better, and on February 25th, after two more injections of 20 cubic centimetres (5 fluidrachms), the temperature fell, the lochia became normal, and the general condition was excellent. In another instance, a weakly infant, aged 3 weeks, and weighing only about 5½ pounds (2.5 kilogrammes) at its birth, was attacked by erysipelas. Forty-eight hours after the appearance of the rash on the upper lip and cheeks 5 cubic centimetres (1¼ fluidrachms) of the serum were injected under the skin. The infant was cured in four days. Its weight rapidly increased, and on March 17th was 6⅔ pounds (3 kilogrammes). This case is the more interesting since erysipelas neonatorum is almost always fatal. The last case was one of severe suppurative tonsillitis, with pseudomembrane containing cocci, occurring in a woman twenty hours after confinement. The temperature varied between 103° and 106° F. (39.5° and 41.1° C.); pulse 148, feeble and irregular. The patient received 60 cubic centimetres (1¾ fluidounces) of the serum the first day, in two injections; 30 cubic centimetres (1 fluidounce) the next day. Thirty-six hours after the first injection the temperature had dropped to 101° F. (38.3° C.), and twenty-four hours later it became and remained normal. Although these cases are too few in number to justify any general conclusions regarding the curative action of the serum, yet they are believed sufficient to demonstrate its harmlessness and to encourage early resort to the treatment.—*British Medical Journal*, May 4, 1895.

GERMANY.

CONGRESS DER DEUTSCHEN GESELLSCHAFT FUR CHIRURGIE, BERLIN.

Etiology and Histogenesis of Carcinoma.—PROF. TILLMANNS, of Leipzig, accepted the theory of Waldeyer and Ribbertz, that carcinoma arises from any subepithelial proliferation by which the epithelial cells are

isolated and made to grow abnormally. Experiments in support of the alleged zymotic origin of cancers have hitherto been without success, the bacilli found in the growth not being capable of producing real carcinoma in other persons. In patients suffering from carcinoma the growth could sometimes be transferred from one organ to another, but a transfer from one person to another has not yet been proved. Carcinoma often arises from prolonged chemical or mechanical irritation; in particular, the use of tobacco is very dangerous as regards the tongue and lips. Hereditary predisposition is unquestionable. Females and negroes are especially liable to it. Cases of carcinoma are rapidly on the increase, their number being at present four times greater than it was forty years ago.

Dr. Geissler, of Berlin, showed a dog to which he had communicated carcinoma by inoculating pieces of a cancer taken from a woman.

Dr. Haussmann, of Berlin, believed that the new growth was carcinoma.

Dr. Friedrich, of Leipzig, said that he had made experiments in reference to the therapeutic action of bacteria toxins on malignant growths. In carcinoma no effect at all could be discovered, but he had reason to believe that in sarcoma his researches might be more successful.

Dr. Lassar, of Berlin, showed patients with cancers of the skin treated successfully by Fowler's solution.

Prof. von Bergmann, of Berlin, declared these cases to be not cancers, but adenomata of the sebaceous glands. Patients with cancers had very often come to him to be operated on soon after an apparent cure had been effected by Dr. Lassar's method. The growth is then usually much larger, and its removal becomes more difficult than it would have been if the previous arsenical treatment had not been undertaken.

Professor Kocher, of Berne, said that the effect of arsenic was only of short duration.

Professor König protested against the publication of methods which have the effect of causing operations to be deferred until too late.

Sterilization of Catgut.—Dr. Lauenstein, of Hamburg, said that he had found in catgut sold as sterilized several kinds of bacteria, such as bacillus subtilis, staphylococcus albus, and micrococcus tetragonus. Suppuration, he was sure, often arose from catgut sutures. In thirty-five out of one hundred and forty-nine specimens of catgut he was able to cultivate the bacteria on gelatin. The greatest number of germs were observed in catgut sterilized by a dry process.

Professor Kocher stated that, in his operations for goitre, primary union was obtained in only 35 per cent. of the cases when sterilized catgut was used, but in 85.7 per cent. when sterilized silk was used. He has now completely abandoned aseptic sutures, and only employs silk made antiseptic by an alcoholic solution of bichloride of mercury. Since adopting this method he has obtained primary union in every case. The question being very important, Professor Kocher suggested the making of a collective investigation, and his proposition was adopted.

Collective Investigation on Anæsthetics.—Professor Gurlt, of Berlin, the secretary of the Congress, read the report, stating that the collective

investigation has now been going on for five years. This year 52,677 new cases were reported, of which 31,808 were chloroform narcosis, with 23 deaths, and 15,712 were ether narcosis, with 5 deaths. In 2148 cases narcosis was produced by a mixture of chloroform and ether, in 1554 by the so-called Billroth mixture, in 1425 by ethyl-bromide, and in 34 by pental. The use of ether has much increased. The mortality from chloroform seems to be much greater than that from ether; but very often grave disorders of the respiratory organs, such as pneumonia and bronchitis, result from the inhalation of ether, and death from those complications ought to be regarded as equivalent to death under anæsthetics. Ether was especially harmful after laparotomy.

Dr. Schleich, of Berlin, explained his theory of the action of anæsthetics. According to him, they are more dangerous the more their boiling-points differ from the temperature of the body. He has devised an anæsthetic mixture (chloroform and petroleum-ether) whose boiling-point is the same as the temperature of the body, and states that he has obtained excellent results, all the disagreeable symptoms (vomiting, etc.) being absent.

Dr. Rosenberg, of Berlin, recommended that the mucous membrane of the nose be brushed with a solution of cocaine before the commencement of the narcosis.

Dr. Rehn, of Frankfort, gave a warning against the use of chloroform near a gas-light, as ethylene-chloride is formed.—*Lancet*, May 4, 1895.

GREAT BRITAIN.

Obstetrical Society of London.

On the Common Form of "White Leg" After Confinement.—Dr. C. Hubert Roberts gave details of sixteen cases of so-called "white leg," most commonly met with after confinement, with a short history of the literature of the subject up to the present date. He pointed out the differences observed in most text-books of the present day, and attempted to show briefly that the white leg described in such books is not the common variety met with after delivery. The form he himself had met with most frequently was not white, but livid, and pitted easily. In its production venous thrombosis played the chief part, and previous hæmorrhage in or after labor was the predisposing cause. He believed that the term "white leg" included several forms of disease which differed in many particulars, and he proposed the following classification: 1. Cases due to pressure. 2. Cases associated with general disease. 3. Cases of a true septic nature. 4. Cases of thrombosis apart from sepsis. 5. Cases of thrombosis and sepsis combined. The author referred in detail to his own (sixteen) cases which followed confinement, and formulated the following conclusions: (*a*) The form which he called thrombotic was the common variety after delivery, and not the brawny white leg, which was rare. (*b*) In such thrombotic legs there are not necessarily signs pointing to sepsis, such thrombosis being rather a blood-change associated with or due to severe loss of blood at the time of

delivery. (*c*) The thrombosis in most cases starts primarily in the uterine and pelvic veins. (*d*) Such thrombotic legs are not brawny and white, but dusky in color and œdematous, invariably painful, with definite "tender spots," the femoral or saphenous veins being constantly thrombosed. (*e*) Both legs may be affected, but always one after the other. (*f*) The onset of the disease is about the tenth to twentieth day. (*g*) Pyrexia is the rule for a variable period, but does not necessarily indicate sepsis. (*h*) Such cases run a definite course of about six to eight weeks. (*i*) Complications are uncommon, but pulmonary embolism is the greatest danger. (*j*) The prognosis in respect to life is good. (*k*) The prognosis for the leg itself is not good; the majority, perhaps, get well, but many remain permanently damaged.

Dr. Horrocks asked whether the proposed classification should apply only to "white leg" occurring as a sequel of labor. He was not sure that the author had made out a difference between classes 4 and 5,—*i.e.*, cases of thrombosis apart from sepsis and cases of thrombosis and sepsis combined,—and he asked on what grounds he had arrived at the conclusion that some cases of thrombosis were not due to any form of sepsis. If the thrombosis were determined by hæmorrhage increasing the coagulability of the blood, one would expect the thrombotic process to follow immediately on the hæmorrhage. This might, perhaps, be explained on the assumption of the clot spreading, but the pyrexia would then have to be accounted for. Again, if white leg were due to increased coagulability of the blood one would expect to find the lesion on both sides at the same time, and not in one leg only or in the one after the other. The most plausible explanation of the left leg being more frequently affected was that the left side of the uterus was more liable to laceration and injury by reason of the occiput generally coming down on that side. He believed both forms of white leg to be due to some form of sepsis. It was possible that in some cases clotting in the veins was more marked than in the lymphatics, while in others the lymphatic element predominated, but this fact did not exclude sepsis. He pointed out that sepsis was not negatived by the absence of any evidence of para- (or peri-) metritis, for the micro-organism might not give rise to any inflammation of the connective tissue.

Dr. G. Herman thought that these were cases of "swelled leg," and not what is technically described as white leg. Thrombosis might exist apart from sepsis, and this was quite a different complaint from thrombosis with sepsis. It would be interesting to know whether white leg occurred in cases in which thorough antiseptic precautions had been carried out. Unfortunately, they were not in possession of any statistics which enabled them to ascertain whether the affection was less frequent now than before the introduction of antiseptic methods. In the rare fatal cases of phlegmasia alba dolens death occurred in quite a different way from death by sepsis. Swelled leg from thrombosis was a different thing from true phlegmasia dolens, which Dr. White, of Manchester, described as "painful white œdema." His own cases had almost always been treated by applications of belladonna and glycerin, and he had been unable to form any opinion as to

the color. Though there was little or no anatomical evidence of the disease being due partly to thrombosis and partly to lymphangitis, there was clinical evidence thereof. The author did not suggest that the loss of blood directly determined the affection, but rather that it favored its production.

Dr. A. Routh suggested that if the author had seen these cases quite in their original state he might possibly have discovered some of the characteristic appearances of true *phlegmasia dolens*. One did not usually see them until the first stage had passed. He related the case of a lady who was seized with acute pain in the left calf, and when he saw her three hours later the limb was two inches larger than the other and presented all the appearances of typical white leg. It was treated by warmth, etc., and by the next morning the swelling had gone down and there was pitting. It was, therefore, quite possible that most of the so-called cases of thrombosis might have begun by lymphangitis. The fact that the affection arose so long after the anæmia showed that it could not be due to mere plugging of the veins, and there was probably, in addition, some change of a septic character,—an assumption which was supported by the rise of temperature. The spreading of the thrombotic process did not explain it either, for he had seen it in cases in which the femoral vein was not obstructed in the least.

Dr. Macnaughton Jones had been struck by the differences observed in these cases in the date of onset, sometimes early,—*i.e.*, between the seventh and eighth days after labor,—while in others it supervened much later; the rapidity with which the brawny state made itself manifest; the early supervention of the "pitting" stage; the rapidity with which this stage passed off; the degree of pain, the variations of temperature, etc. Personally he had always felt more disposed to adopt Tilbury Fox's view, that the affection began in the lymphatics rather than in the veins, and possibly some of the differences observed might be due to the predominance of the changes in the veins and in the lymphatics, respectively. He agreed with the view that the affection sometimes occurred independently of sepsis. Pressure as a cause was proved by two cases which he had met with, in which no symptoms, whatever, of any septic condition were present previous to the characteristic appearances of phlegmasia. This pressure had been accounted for anatomically by the peculiar injuries to which the left side of the uterus was supposed to be liable, but that view did not commend itself to him. He pointed out that on the left side the artery overlay the vein, which was a more likely cause of pressure. He had seen cases occurring independently of labor in which there was no possible septic cause in which phlegmasia had developed. In several it developed in varicose veins of the leg after an illness of some kind, and the trouble probably began in the lymphatics. Oscillations of temperature after labor were often noted quite apart from any complication of this kind; so that the mere rise of temperature was not enough to enable them to affirm that there was sepsis. Moreover, there might be no discoverable condition in the uterus or its annexes to account for the leg trouble.

Dr. Griffith agreed that there were essential differences between the disease as described in text-books and those due to simple thrombosis.

He did not think the author's explanation was quite admissible as to the cause of the thrombosis. He had examined two cases very carefully, post-mortem, and in both the thrombosis had extended from the uterine sinuses up the uterine veins. Given the size of the latter, it was quite conceivable that they might be thrombosed without giving rise to any constitutional symptoms, and it was not until there was a sudden interference with the circulation in such a large part as the leg that characteristic symptoms appeared.

Dr. Robinson mentioned that Vidal, of Paris, claimed to have discovered in many of these cases a streptococcic invasion of the thrombosed veins. By others the bacillus coli communis had been incriminated, though of this no direct evidence had so far been adduced.

Dr. Champneys failed to see that Class 1 was necessarily different from Class 4, because pressure would be very likely to lead to thrombosis. He remarked that, in the author's cases of double phlegmasia, the disease commenced in three out of the four on the right side, which in his own experience was quite exceptional.

Dr. A. Giles observed that in only one case was the history of sepsis at all definite, in which there was abscess, with sloughing. That case was one of miscarriage at three months, whereas all the other cases appeared to have occurred after delivery at term. The explanation of the left side being more frequently affected in consequence of the nature of the presentation did not appear to be valid, for, if the down-coming head caused the trouble, its effects would be mainly appreciable on the cervix, and the pelvis would suffer rather than the leg.—*Medical Press and Circular*, May 8, 1895.

SWITZERLAND.

Réunion Générale des Médecins Suisses. Société Vaudoise de Médecine.

Meeting of May 4, 1895.

Lateral Hæmatocolpos.—M. Muret, of Lausanne, had occasion to observe and afterward to operate upon an interesting case of lateral hæmatocolpos in a young woman, aged 18, who had had irregular menstruation for several months and suffered from dysmenorrhœa of increasing intensity. An elastic tumor appeared above the symphysis pubis and formed a marked prominence in the vagina. An incision in the lower part of the tumor gave issue to about 2 litres (quarts) of chocolate-brown colored blood, very ropy and viscous. After the operation the pains disappeared and menstruation returned regularly. A further examination of the patient under ether showed that the vagina was double; the right, which was the seat of the atresia, was the least developed, its cavity being divided in two by a diaphragm with a large excentric orifice; the vaginal portion of the uterus was slight; the uterus itself was small, but well formed, and on its left an ovary could be felt. The left vagina, which was open, was narrowed considerably toward the top, and ended in an orifice which communicated with the right

vagina. This co-existence of a single uterus, *non unicorne*, with two vaginæ is very rare, and is explained by a fusion of Müller's ducts, complete on top but incomplete below. It is also curious to note that the vagina showing atresia was best developed, while the other, which was rudimentary, was permeable. The presence of menstruation prior to the operation is explained by the communication between the two vaginæ. Hence, from a practical point of view, the evident importance of a careful examination in all cases of dysmenorrhœa, in order that similar conditions may not escape observation.

The Relation between Serous Pleurisy and Tuberculosis.—PROFESSOR EICHHORST, of Zurich, remarked that in a certain number of cases the relation between serous pleurisy and tuberculosis should not be overlooked, because patients cured of serous pleurisy run a great risk of becoming tuberculous later on. Bass has found that at the end of five years only 33 per cent. of such patients were still living; however, tuberculous areas are not always found at autopsies, and the two diseases are so frequent that it is often difficult to say which of them was the primary affection. For a long time he has submitted the pleuritic effusion to microscopical examination, and when bacilli are present the diagnosis is not doubtful; if they are not, however, one has not the right to exclude tuberculous infection, but should then have recourse to experiments.

In a series of such experiments he injected, with a Pravaz syringe, 1 gramme (15½ minims) of effusion into the peritoneal cavities of 11 guinea-pigs; 10 of these remained perfectly healthy, while 1 only showed a tuberculous infection of the abdominal lymphatic glands. These results correspond to the observations of other authors. He thought that perhaps the volume injected was insufficient to insure the invariable presence of bacilli in the injected dose. He therefore had a syringe made by means of which he injected 15 cubic centimetres (½ fluidounce), and the results were entirely changed; twenty-three such injections of serous effusion to as many guinea-pigs infected fifteen, or 65 per cent. Five of the patients, whose pleuritic effusions have been used in these experiments and infected the animals with tuberculosis, returned to his service later on with tuberculosis. It must, therefore, be admitted that two-thirds of the cases of serous pleurisy are in fact tuberculous, and that recoveries in most of the cases are but conditional. The infection originates but rarely in the lungs, generally in the tracheo-bronchial glands. By the same method he found that in 27 cases of serous pericarditis, 8, or 29 per cent., were of tuberculous origin. It is probably the same with other serous affections, and those which are called spontaneous are without doubt very often infectious tuberculous cases.

M. DE CÉRENVILLE, of Lausanne, expressed the opinion that tuberculous pleurisy presented differential characteristic signs: hyperthermia was much less, often not exceeding 38° C. (100.4° F.), and the effusion was more quickly produced. On the other hand, it sometimes happens that, even if the pleurisy were tuberculous, tuberculosis never develops. He considered the prognosis of Dr. Eichhorst as, perhaps, a little too dark.

DR. SOCIN, of Bâle, believed that in patients stricken with surgical

tuberculosis a history of serous pleurisy may be often found; in several hundred cases where no pulmonary symptoms could be proved 8 per cent. had had anterior serous pleurisy, and often many years had elapsed before the appearance of surgical tuberculosis. This form of the disease seems to develop sooner than pulmonary tuberculosis.

Operations for Cancer.—Dr. Roux, of Lausanne, discussed this subject and remarked that the former teaching concerning constitutional cancer, the absence of antisepsis, and the fear of relapse discouraged the most intrepid surgeons from attempting on malignant tumors any but insignificant and palliative operations. From the characteristics of cancer he admits that it is a parasitic disease resembling tuberculosis in its clinical evolution; it is necessary, therefore, to attack it with the same energy and promptness as the latter affection. Too often we operate too late, when it is impossible to prevent a relapse. This fact filled the earlier statistics and continues to darken the present ones. As soon as the diagnosis is assured we should intervene by the bloody method, always making a systematic and carefully-detailed toilet of the ganglionic chain, even if it is healthy in appearance. That the principal cause of relapse is the late period at which we operate is proven by his personal observations upon three groups of cancer cases: those of the breast, the uterus, and the gastro-intestinal tube. The operable cases of cancer of the stomach reached 12 per cent.; those inoperable, 88 per cent., a part of which were susceptible of palliative operation. The mortality from pylorectomy for cancer was from one-fifth to one-seventh; that from gastro-enterostomy, one-seventh. For cancer of the uterus there was 68 per cent. of the cases inoperable and 32 per cent. operable, only one-fourth of which were operable by the sacral method. The mortality from vaginal hysterectomy was 8 per cent. and from sacral hysterectomy 11 per cent. As regards cancer of the breast, for which intervention is most easy, he counts twelve absolutely inoperable cases, while in more than 50 per cent. of the cases it was possible to predict an early and fatal relapse. The mortality reached 5 per cent.,—that is to say, it was equivalent to the general mortality of all the operations. There is no doubt that early operations will prevent relapses, since in the deplorable conditions under which we now operate we actually have some cures. He cited at hazard cases of gastro-intestinal cancer without apparent relapse for three years; cancers of the rectum without relapse after four years; a cancer of the uterus, which had invaded the vesical walls; a villous cancer of the kidney of extraordinarily difficult extirpation and without relapse for five years. He had removed the tongue in a case that had relapsed nine years after an operation by Dr. Kocher. Among his cases was one of survival for eleven years from cancerous goitre, and a cancer of the testicle that had not relapsed at the end of twelve years. Histological examination had left no doubt as to the nature of these tumors.—*Semaine Méd.*, May 8, 1895.

UNITED STATES.

SOCIETY OF THE ALUMNI OF CHARITY HOSPITAL, NEW YORK.

Movable Spleen in an Infant, Caused by Malarial Enlargement.—DR. CHARLES J. PROBEN presented the case of an infant, aged 13 months, a foundling, which, on admission to the hospital, had been vigorous, well developed, and without any apparent blemish. After some time the babe lost flesh and became anæmic, cross, and irritable. Its miserable condition was attributed to defective nursing, and it was given to another nurse, with the same result. Aside from the extreme irritability and frequent rises of temperature, nothing was noticed until the nurse discovered a swelling on one side of the abdomen. This unilateral swelling, after a careful examination, was pronounced to be a large hypertrophied spleen, occupying one-half of the abdominal cavity. The osseous system of the infant revealed certain changes caused by rachitis. The author stated that very large spleens in infants, excluding neoplasms, especially carcinoma, sarcoma, also cysts and abscesses, were due to three causes,—leucocythæmia, malarial poisoning, and syphilis. Enlargement of the spleen in children could only be positively diagnosticated by palpation; percussion was too uncertain and dubious. In the case reported leucocythæmia had been excluded by the absence of large glands, either apparent or hidden, also by a microscopical test of the blood. Syphilis had been excluded by the absence of any lesions of the skin, mucous membrane, teeth, nose, etc. The general adenopathy was attributed to the rickety condition of the infant. Malarial fever seemed the only feasible conclusion, judging partly from the symptoms and partly by exclusion. A microscopical examination of the blood showed pigmented bodies, translucent oval bodies, and rosette-shaped bodies in the red blood-cells, also on one occasion a crescent-shaped body. The presence of the plasmodium and the large hypertrophic condition of the spleen made the case very interesting, considering that such cases were rare in New York. A proper course of quinine administration was instituted, the patient receiving 2 grains of the sulphate three times a day, alternated at times with the liquor potassii arsenitis. After two months the symptoms, with the fever, began to disappear, the patient improved in health, the spleen diminished until the abdominal swelling disappeared, and the spleen, about four inches long by two inches and a half wide, could be felt feebly movable in the abdominal cavity, freely displaceable up and down, the contour suggesting a splenic tumor loosened from its attachments. The author thought this a movable hypertrophied spleen, and had arrived at the following conclusions: 1. That this displacement could alone be attributed to the immense size, due to malarial poisoning. 2. That the cause of the malarial infection could not be ascertained, whether fœtal or later acquired from the nurse. 3. That a microscopical blood examination in cases of a doubtful character was requisite, and that even where it was negative or dubious one must resort to the therapeutic test,—large doses of cinchona alkaloids, preferably quinine. 4. That intermittent fever in infants in New York City was rare; where the microscope could not decide, therapeusis must. 5. That

enlarged spleen in infants was not alone due to malaria, but more frequently to rickets and other conditions. 6. That palpation of the spleen was the only feasible and certain method of diagnosis. 7. Symptoms of paludal poisoning were frequently referable to the gastro-intestinal canal, and less often to the lungs, which responded to quinine. 8. The stages of chills and sweating were absent in infants. 9. A fever of periodical character, with enlarged spleen, other causes than malaria being excluded, demanded quinine.

Dr. White spoke of a case of enlarged spleen that he had seen in a child 7 years old. The enlargement had rapidly disappeared under the use of arsenic, quinine, and iron. He believed such cases were rare.

Dr. Newton said cases had been reported that were congenital, due to malarial disease in the parents, and he thought it extremely likely that the case reported by Dr. Proben was of such a nature. The child was not in malarial surroundings when the temperature rose. He spoke of a case of splenic enlargement under his observation. In the blood there was a large preponderance of the white corpuscles. It was a case of spleno-medullary leucæmia, and offered many interesting phases for study.

Dr. Proben stated that in looking over the literature on the subject he had noted three cases of fœtal malarial disease. One was that of a woman, suffering from malarial poisoning, who noticed, in the last month of pregnancy, a fluttering of the abdomen every night. When the child was born it had an enlarged spleen. It had seven paroxysms; was put on quinine and improved.

Carcinoma Mammæ.—Dr Wells gave the history of a thin, anæmic woman, 57 years old, who had first noticed a small lump in her right breast eight years before. This lump had remained almost stationary, caused her no pain, and did not seem to interfere with her general condition. When he saw her she presented a freely-movable, stony, hard nodule, of the size of a hickory-nut, just beneath the slightly-retracted nipple of the right side. There was no appreciable thickening or enlargement of the lymphatics in the axilla or beneath the edge of the pectoralis major. The breast was removed, together with the overlying skin, the pectoral fascia, part of the pectoral muscle, and the axillary contents *en masse*. These included the contents of the space between the clavicle and the upper border of the pectoralis minor muscle and of that between the pectoralis major and the deltoid just below the clavicle. Convalescence was rapid and uneventful. A microscopical examination of the shot-like glands removed showed carcinomatous infiltration everywhere. This proved very certainly that the disease had extended beyond the reach of any justifiable surgical measure and that recurrence was inevitable. A condition like the one reported was to be expected in any case where the primary cancerous nodule had existed for any considerable time, and the case strongly exemplified the fact that surgical interference, to be successful, must be *early*.—*New York Medical Journal*, April 6, 1895.

Selections from Reports of Members of the Annual's Staff of Correspondents.

Denmark.

DR. HOLGER MYGIND,
REFERENT FOR DEN DANSK LITTERATUR VEDRØRENDE: ALMINDELIG KIRURGI, OPHTHALMOLOGI, LARYNGOLOGI, OTOLOGI, ANATOMI, HISTOLOGI, PHYSIOLOGI, DERMATOLOGI, SYPHILIDOLOGI, SAARSYGDOMME (TETANUS, HYDROPHOBI, ETC.).

Alle medicinske Böger, Disputatser, Monographier, Tidsskrifter, etc., der adkomme i Danmark bedes sendt til DR. LEVISON,
(f. d. DR. MYGIND),
Norrevoldgade, 18,
Köbenhavn.

Adenoid Vegetations.—The well-known discoverer of adenoid vegetations, DR. WILHELM MEYER, of Copenhagen, has written an elaborate and interesting article (*Hospitals-Tidende*, Nos. 6 and 7, 1895) on the extension of adenoid vegetations and the age at which they occur. He has tried to collect evidence of their existence in different parts of the world and in different races. In Greenland, amongst 60 Esquimaux children between 6 and 14 years of age, Dr. Helms only found 16 free from adenoid vegetations. In North Dakota Dr. Quarry found adenoid vegetations frequently amongst the native tribes of Indians, but the growths were very little developed in adults. Dr. Cautley, of Hong Kong, reported that the native Chinese of the Mongolian race, as also those belonging to the mixed Chinese-Portuguese race, frequently suffered from them; while, in Bangkok, Dr. Demitzer rarely found the disease amongst the native Siamese. Dr. Romback, Medical Superintendent of the Dutch-Indian Colonies, collected evidence from several military surgeons with the following results: In Singkil, on the northwest coast of Sumatra, 113 natives were examined; of these, 3—*i.e.*, 2.6 per cent.—had adenoid vegetations; on the island of Amboika 326 school-children were examined, none of the girls and 2 of the boys (0.8 per cent.) being found to have adenoid vegetations; on the island of Saparoa none of 100 adults examined had the growths mentioned, while 5 out of 717 school-children (0.7 per cent.) suffered from them. Dr. Meyer accordingly comes to the conclusion that adenoid vegetations are to be found in varying degrees of frequency in at least three parts of the world, viz., Europe, America, and Asia; the Mongolian race is almost as much predisposed as the Arian; a warm climate seems less favorable to their development than a cold one. He has, furthermore, with great perseverance, studied portraits and busts in numerous European collections in order to detect, as far back as possible, undoubted sufferers from these growths. As a proof of the existence of adenoid vegetations in the beginning of our century, the numerous likenesses of the famous sculptor Canova are mentioned, all showing the artist with an open mouth, a narrow nose, and a languid look; and one of his pupils has also stated that he was somewhat deaf. There is also undisputed evidence that the Emperor Charles the Fifth had adenoid vegetations, his portraits showing a face typical of these growths; he also notoriously suffered from asthma, and that this disease was not produced by nasal polypi is proved by the fact that the portraits taken early in life are much more typical than the later ones. King Francis the Second, the first husband of Mary, Queen of Scots, who, according to the French otologist (Potiquet's recent investigation), suffered from adenoid vegetation, had, according to Dr. Meyer's opinion, perhaps suffered from

these growths; but he points out that, the nose being far from typical, doubt must therefore exist whether he did not suffer from nasal polypi. Amongst specimens of ancient sculpture Dr. Meyer has not found a single instance which might serve as a proof of the existence of adenoid vegetations in Greece; this may, however, be easily explained by the fact that the ancient Greek artists had a tendency to idealize the human features. Several ancient Roman statues and busts, on the contrary, show undeniable evidence that adenoid vegetations existed as far back as Roman art goes. As the most pronounced examples Dr. Meyer mentions Nos. 80, 189, and 192 of the Chiaramonti Gallery in the Vatican, of which three busts the two first mentioned represent children. He finally concludes that it is probable that adenoid vegetations have at least existed ever since the early ages.

The Use of General Anæsthetics in the Removal of Adenoid Vegetations.—DR. ARNOLD LARSEN, of Nykjäbing, Denmark, having strongly recommended the administration of chloroform in all cases of removal of adenoid vegetations (*Bibliothek for Laeger*, p. 371, 1894), DR. HOLGER MYGIND, of Copenhagen, in an article in the *Hospitals-Tidende*, No. 37, 1894, feels it necessary to warn against their indiscriminate use in this operation. His principal objection is the great danger, as shown by the comparatively-numerous cases of death reported in English medical literature, most of the patients having been healthy children. He is inclined to believe that these frequent fatal results are due to the fact that the operation concerns a part of the respiratory organs, and that, being considered a minor one, the narcosis is less attentively watched. Another objection is that the administration of a general anæsthetic, in the vast majority of cases, is unnecessary; personally he has only been obliged to use general anæsthesia in 4 out of 254 operations performed by him. Wilhelm Meyer, H. Schwartze, B. Fränkel, Kuhn, Trautmann, and many other well-known specialists are also in favor of operating generally without narcosis. If, however, narcosis is considered necessary, Dr. Mygind advises the use of a very superficial anæsthesia without discontinuation of the normal reflexes, the patient resting upon the right side, with lowered head.

Animal Trichophytosis.—A man, aged 37, who was employed by a butcher, suffered from an extensive dermatomycosis of the right side of the neck and face. H. PRIP, of Copenhagen (*Hospitals-Tidende*, No. 31, 1894), who examined minutely the hairs, found in each case that the hair itself was free, while the sheath was invaded by spores and mycelium of trichophyton. The spores only measured 3 to 4 μ, but the author nevertheless considers this skin disease as the result of the invasion of the macroscopical form of trichophyton described by Sabouraud, partly on account of its clinical appearance, which resembled exactly that described under the name of *Sycosis trichophytique à dermatite profonde*, and partly because the mycosis was extra-pilar and accompanied by the formation of mycelium, some of the spores also exhibiting double contours. The author has no doubt that the disease was communicated from a calf, the patient often carrying calves on his right shoulder in such a way that their skin exactly touched the part of the body invaded by the disease; the patient also

voluntarily stated that he had noticed that several of the calves he had carried suffered from "ringworm." Dr. Prip examined the fellow-workers of the patient and found one, a man aged 20, with a developed tinea on the right forearm. Microscopical examination revealed the same details as described above. In the second case, however, the mycelium contained yellowish spores, while in the first it did not.

Bacteriological Examination of Two Hundred and Sixteen Cases of Diphtheria.—DR. F. THYMANN (*Hospitals-Tidende*, Nos. 10 to 13, 1895) examined bacteriologically 216 patients admitted to the Copenhagen County-Hospital with a diagnosis of diphtheria, his results being as follow:

Number of Patients.	Appearance of the Fauces.	Lœffler's Bacilli.*	Lœffler's Bacilli.*	Short Bacilli.
19	Redness and swelling . .	12 cases.	7 cases.	0 case.
29	Lacunar deposits	10 "	17 "	2 cases.
31	Small membranes	16 "	12 "	3 "
133	Extensive membranes . .	98 "	34 "	1 case.
4	Fauces not examined* . .	3 "	1 case.	0 "
216		139 cases.	71 cases.	6 cases.

Amongst other cases the author mentions that of a child, aged 9, in whom both tonsils and the uvula were entirely covered by a gray, fetid membrane, and, later, the tonsils were covered with deep ulcerations, the uvula being totally destroyed by the ulceration. Repeated examinations, however, only revealed the existence of streptococci. In all cases of tracheotomy the bacteriological examination of the secretion from the cannula gave exactly the same results as the bacteriological examination of the fauces, the total number being twenty-six. Of the 216 cases mentioned above, 36 were complicated with croup, and only 3 of these were free from Lœffler's bacillus. Dr. Thymann gives an interesting account of four brothers and sisters infected at the same time and in whom the bacilli found in all four cases were exactly alike, while the clinical appearance of the disease differed in all four.

Intermittent Dislocations Due to Reflex Spasms.—DR. ZENS SCHON, of Copenhagen (*Ugeskrift for Læger*, No. 23, 1894), reports the following two cases, which seem to be rather unique: 1. A girl, aged 14 months, with pronounced symptoms of rickets, but otherwise healthy, had for three months exhibited the following peculiarity: When sitting on her mother's lap with the crura hanging down loosely, a cracking or clicking noise was constantly heard; at each crack the tibia was seen to be quickly dislocated outward so that part of the external condyle was felt under the skin, being, however, soon after, with another cracking noise, brought spontaneously back into its normal position. One tibia was generally affected at a time

* In all these patients tracheotomy was performed at once and the secretion from the cannula was examined bacteriologically.

in this manner, the intervals between each dislocation being of different length,—from a few seconds to minutes. The child was able to stand up and walk without the spasms appearing, but was not able to walk without assistance. It was impossible to ascertain which muscle or group of muscles contracted during the dislocation, which could also be produced by the hand of the examiner. 2. Shortly afterward Dr. Schon saw another girl, aged 13 months, who exhibited the same phenomena; in this case, however, the head of the femur was dislocated, but only when the patient was lying on her back, and especially when she got angry and kicked her legs. The head of the bone was felt distinctly under the skin, against the posterior and superior margin of the acetabulum. The child was perfectly healthy. Dr. Schon believes the dislocation in these cases to be produced by spasms caused by reflexes from the joints, when these are brought in certain positions.

Poland.

DR. J. DRZEWIECKI,

Redaktor Korespondent z działu polskiej literatury tyczącej się: Medycyny ogólnej i lecznictwa; pedjatryi; akuszerzyi; ginekologii; laryngologii; otologii; hygieny; demografii; medycyny sądowej; histologii; patologii; bakteryjologii; anatomii; fizjologii.

Wszystkie pisma lekarskie, dzieła, rosprawy, monografije, itd., w jezyku polskim wydane, a tyczące się przedmiotów powyższych, winny być nadsyłane pod adresem

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Reaction of Diphtheritic Bacteria.—DRS. PALMICSKI and ORLOWSKI (*Medycyna*, February 16, 1895) have proved that cultures of diphtheritic bacteria give the same reaction as mineral acids (muriatic and sulphuric) on indol, and as cultures of cholera bacteria; by the addition of acid a purple-rose coloring is obtained. Young cultures do not give the reaction, but those three weeks old give it very distinctly. According to their experiments, the presence of indol, together with azolitmin, is necessary to obtain the reaction. In young cultures there is little, if any, azolitmin, and, therefore, the reaction is not obtained in spite of the presence of indol, which gives the other distinct reaction, such as Légal's reaction. The experiments proved also that cultures filtered through a Chamberland filter gave, with acids, a rosy color, whereas the filtrated bodies of bacteria do not show such coloring.

Treatment of Tuberculosis of the Joints.—PROFESSOR RYDYGIER, of Krakow (*Przeglad Lekarski*, No. 15, 1895), read a paper on this subject at the Seventh Congress of Polish Physicians in Lemberg, his conclusions being as follow: 1. That conservative treatment should not be looked upon as a competitor of operative treatment; on the contrary one should be the complement of the other. 2. The treatment chosen in a given case should depend on the social position of the patient, his age, general state of health, local changes, and on the joint affected. 3. If there is distinct suppuration of the joint, with inclination to spread and destroy the joint, it is necessary to operate. 4 The better the method of conservative treatment, the more we can limit the operation. 5. The best method of conservative treatment is that which permits the patient to profit by fresh air and movement such

as will not expose the joint to irritation. 6. The best method of conservative treatment is that which best permits of the removal of the morbidly degenerated parts without any special regard to later action of the joint; in some cases, however, the complete removal of the joint is advisable. 7. Operations performed too late increase the statistics of conservative treatment, but are not advantageous to the patients, while too early operations only injure unnecessarily. 8. In addition to local treatment, sea-air and suitable baths are recommended as general treatment.

Disturbances of the Spinal Cord after Typhus Fever.—DR. S. TERZYKOWSKI (*Nowiny Lekarskie*, No. 10, 1894) has examined three cases of nervous disturbances after typhus fever, diagnosing transverse myelitis in two cases and disseminated myelitis in the third. One case ended in complete recovery, but in the others complete recovery did not ensue, and the patients were lost to sight. The question as to whether these disturbances are occasioned by the typhus bacilli or by their toxic products has not yet been solved. The noxious factors reach the nervous centres through the lymphatics and blood-vessels, as well as the peripheral nerves.

Russia.

DR. J. DRZEWIECKI,

РЕДАКТОР-КОРРЕСПОНДЕНТ изъ области русской литературы, касающейся: Общей медицины и терапіи, педіатріи, акушерства, гинекологіи, ларингологіи, отологіи, гигіены, демографіи, судебной медицины, гистологіи, бактеріологіи, анатоміи и физіологіи.

Всѣ періодическія, медицинскія изданія, сочиненія, стат'и, монографіи и т д., изданныя на русскомъ языкѣ и касающіяся вышепоименованныхъ предметовъ должны быт' адресованы на имя

ДРА ДРЖЕВЕЦКАГО.

67 Краковское Предмѣст'е, Варшава.

The Treatment of Diphtheria by Antidiphtheritic Serum.—DR. TESIAKOFF (*Vratch*, No. 10, 1895) communicates the results of this treatment in 20 cases, in only 1 of which bacteriological examination was made. Besides the injections, unguentum cinereum was applied externally. In 8 patients the injections were made on the first or second day of the disease; the highest temperature was 39.3° to 39.8° C. (102.6° to 103.6° F.); all recovered. In 12 cases the injection was not made before the third day, and 6 died. In 3 there was malignant diphtheria and the serum had no effect. The favorable action was generally observed on the second day after the injection, manifesting itself by a relatively slight diminution of temperature, by decrease of the swelling of the glands of the neck, and by amelioration of suffering. The mortality in these cases was 30 per cent., as compared with 48.9 per cent. previously. Of 14 children to whom injections were given for prophylactic purposes only 1 became ill.

[To appreciate the results of this treatment it is necessary to remember that, in cases treated by serum in Russia and other countries, the hitherto-favorite methods of brushing or painting the throat, etc., were avoided and the principle that the affected organ must be kept quiet was followed. Naturally such changes in the treatment must needs have influenced the results.—CORR. ED.]

Sweden.

DR. F. EKLUND,
Brefväxlande Medarbetare
för den
SVENSK MEDICINSK
LITTERATUR.

Af alla i Sverge utkommande medicinska tidskrifter, bocker, afhandligar, monographier a. s. v. torde ett exemplar benåget öfversändas till

DR. ABRAHAM
FREDRIK EKLUND,
Sibyllegatan, 3 A,
Stockholm.

Abdominal Lipoma.—DRS. IVAN LUNDIN and CHARLES HEDBOM (*Upsala läkareförenings förhändlingar*, vol. xxx, No. 2) mention the case of a carpenter, aged 52 years, who, about seven years previously, had observed that his abdomen began to swell, that his appetite diminished, and that he became irritable, was troubled with flatulence, painful colic, and oppressive dyspnœa, and that the urine considerably decreased in quantity. The circumference of the abdomen increased by degrees and in a uniform manner, and in the right iliac fossa there appeared a tumor which reached the umbilical line transversely and the median line below. Laparotomy was performed and proved that the tumor filled the entire abdominal cavity, with close vascular adhesions to the cæcum, the ascending colon, and the hepatic angle of the colon. The tumor had also partly surrounded the transverse colon. Lennander, who operated, noticed that the right portion of the large omentum was entirely missing after the operation, and that the serous membrane, particularly the superior part of the mesocolon had been injured in a large portion. He fixed in the wound of the abdominal wall one part of the transverse colon, more than twenty centimetres long, without the mesocolon. Gangrene and venous thrombosis supervened, but recovery ensued after four applications of the enterotome. The extirpated lipoma was sixty centimetres long and forty centimetres wide, twenty centimetres at its greatest thickness, and weighed 17 kilogrammes (37½ pounds).

Antitoxin in Diphtheria.—DR. HELLSTRÖM read a paper before the Swedish Medical Society (*Hygeia*, vol. lvii, p. 73) on four cases of diphtheria treated with antitoxin. Two were treated with Behring's serum and both recovered, and two with Roux's serum, one dying. He considers it of great importance to inject the serum early and at the right moment. In the three patients who recovered symptoms of paralysis appeared, but he has not observed in his hospital-work any dangerous or hurtful influence; and the fact that the remedy shows such slight antitoxic properties has caused his confidence in it to waver.

Cataract.—DR. GUSTAF AHLSTRÖM (*Göteborgs läkaresallskaps förhändlingar*) reports 100 cases of cataract operated upon by the so-called modified linear extraction method, only 1 being followed by suppuration. There were 54 men and 46 women; the oldest patient was 82 years, and the youngest 35 years; the right eye was operated on in 51 cases and the left in 49; a traumatic cataract was present in 5, and an immature cataract in 12. As a general rule, cataract in persons of 50 years of age or more should be operated on as soon as the visual strength has become so lessened by the opacity of the lens as to prevent the performance of daily avocations. In 73 of his cases the result was good, in 26 passable, and in 1 bad. The

author believes that, even if this method of operating in combination with iridectomy have its advantages, the simple method has still greater, and iridectomy, so far from being an unnecessary mutilation of the eye, really increases the chances of a good result.

Gonorrhœa.—DR. CHARLES EKELUND (*Hygeia*, vol. lvii, p. 56) has treated 125 cases of gonorrhœa according to Janet's method, commencing with a 1 to 4000 permanganate of potassium, and increased to 1 to 3000, 1 to 2000, and 1 to 1000. Precautionary measures should be observed in opening the faucet of the catheter so that the fluid will at first run very slowly. The irrigations should not be employed until after the acute inflammatory symptoms have subsided, and then only once daily; careful attention should be paid to the reaction of the mucous membrane of the urethra and of the bladder; the strength of the irrigating fluid must be cautiously increased and the pressure be moderate. The method is considered as no more dangerous than the injections hitherto in use.

Tabes Dorsalis.—L. WOLFF (*Göteborgs lakäresallskaps forhändlingar*) has studied three cases of tabes dorsalis in which the so-called gastric crises were not only the first, but the dominating, symptoms of the disease. There was a constant lack of hydrochloric acid both during the crises and in the intervals between them. In order to lessen the sensibility of the nervous apparatus of the stomach, as well as the entire nervous system, the author recommends nitrate of silver (0.01 gramme—$\frac{1}{6}$ grain) and extract of belladonna (0.05 gramme—$\frac{7}{8}$ grain) to be given, during the free intervals, an hour before meals. He also recommends galvanization of the spine, neck, and abdomen, in sittings of not longer than five minutes, every day or so for several weeks, with tepid baths at a temperature never below 20° to 22° C. (68° to 72° F.).

Cholecystotomy—DR. C. DE HEIDEKEN (*Finska lakäresallskapets handlingar*, vol. xxxvi, No. 12) reports the case of a peasant-woman, 56 years old, who some years ago was affected with a fever of long duration. For many years she had pains in the right shoulder, descending the length of the thorax and below toward the liver and the right lumbar region. Immediately beneath the right costal edge there was a smooth and hard tumor nearly the size of a fist. She was reduced in flesh, of cachectic complexion, but without icterus or digestive troubles. The thickened edges of the liver did not exceed the normal limits. Cholecystotomy was performed and showed the biliary vesicle distended like a sausage and slightly transparent. An incision four centimetres long was made, and about 200 cubic centimetres ($6\frac{1}{2}$ ounces) of a glairy, grayish fluid were evacuated with 12 biliary calculi, varying in size from that of a pea to a plum, some round and some angular, the largest of which, nearly spherical, were situated immediately in front of the orifice of the biliary vesicle. Fine catgut sutures were fixed through the walls of the bladder in such a way that the layers of serous membrane lay one upon the other.

Clinical Notes.

A New Case of Peripheral Neurotabes.—Prof. Dejerine reports, in the *Revue de Médecine* for April, a case which corresponds closely to the clinical picture of the affection described by him in 1883 and 1884 under the name of peripheral neurotabes, or locomotor ataxia from peripheral neuritis (*Comptes rendus de l'Acad. des Sci.*, p. 231, 1883; *Arch. de phys. norm. et path.*, p. 231, 1884; *Arch. de méd. expérimentale*, p. 251, 1888). A man of 42 years presented himself on account of difficulty in walking and in maintaining his equilibrium. There was no hereditary history, and his personal antecedents also showed no special trouble. The man had not had syphilis, and had always been of sober habits. Married at the age of 26 years, he had one daughter, now 15 years old. His business was that of a negotiator, or business-agent, in one of the provinces. With the exception of slight dyspepsia he had always been healthy. His first severe illness occurred the previous year, and he was sent to Spa in September, 1894, on account of digestive disturbances. While there he was attacked with pseudomembranous angina, diagnosed as diphtheritic, accompanied by high temperature and a serious general condition. This illness lasted ten days, and, as soon as the symptoms of angina disappeared, the patient insisted upon returning to his home, where he appeared to entirely recover his former health. About a month after the appearance of the angina he began to feel a creeping sensation in the legs and to notice that he walked less firmly. These symptoms grew more pronounced until, by the end of November, walking became more and more difficult. He also noticed that the skin of the feet, legs, and hands had almost completely lost their sensibilily. Prof. Dejerine examined him toward the end of December, and found him to be an apparently vigorous man, looking somewhat older than he really was, and walking by means of a cane. The walk was of the ataxic type in the medium stage of inco-ordination, the legs being thrown brusquely forward and outward, the heel dropping with equal suddenness to the ground. He leaned the right hand upon a cane, and at the same time regarded fixedly the spot where he was to place his foot. When told to look upward the inco-ordination increased greatly, he seemed anxious, made false steps, and would have fallen if not supported. He could not stand with the eyes shut (Romberg's sign) even when leaning on his cane, and could not keep his equilibrium on one leg with his eyes open. He had observed for a month previously that the difficulty in walking was much greater in the dark.

The muscles of the lower extremities were normal as regards size and strength, there being no trace of paralysis or atrophy. When the patient was told to resist, it was impossible, even by employing considerable force, for Prof. Dejerine to flex or extend the legs upon the thigh, and the same was true of the feet; while, to show that the muscular strength was unaffected, the patient offered to lift the author on his shoulders, and did so quite easily. Faradic and galvanic reactions of the muscles of the lower limbs were quite normal. Idiomuscular contraction was not obtained by percussion, and there were no fibrillary contractions. The patellar reflexes

were quite abolished on both sides, as was also the cutaneous reflex. There was no pain in the lower limbs, and no distinct pain on pressure over the nerve-trunks. The patient complained only of a heaviness in the feet, and in walking did not feel the resistance of the ground, but had a sensation as if he were walking on cotton. Objective sensibility was much altered. The sense of touch on the dorsal and plantar surface of the feet and the lower two-thirds of the legs was abolished, and above this limit it began to re-appear little by little until, at the lower fourth of the thighs, it became normal. Sensibility to pain was altered in the same regions and in the same proportions as tactile sensibility, transmission being retarded, with some hyperæsthesia. This retarded transmission, which diminished from below upward, reached three or four seconds on the plantar and dorsal surfaces of the feet. Temperature sensibility was similarly altered. Muscular sensibility appeared to be little affected, the patient recognizing the position of the limbs with the eyes closed. The sense of position, on the other hand, was markedly altered. He localized badly any painful irritation, and when told to touch his great toe or ankle with his eyes closed, and with the index finger of the left or right hand, made marked mistakes as to position. In the dorsal decubitus there was marked inco-ordination, increased when the eyes were closed, the patient being unable to place the heel of one foot on the ankle of the other without a considerable number of attempts.

The upper extremities were intact as to size and strength, without distinctly-appreciable inco-ordination. The dorsal and palmar surfaces of the hands were affected in the same manner as the feet, the patient feeling as if his hands were always covered with gloves. The olecranon reflexes were weakened. The face was normal, as were the muscles of the tongue and larynx. There was no paralysis of the muscles of the eyes; the pupils were equal and of ordinary size, reacting normally to light, accommodation, and pain. The sight was good, and hearing, taste, smell, and speech normal. The pulse was 72, the heart-beats regular, and the general health excellent. The vesical and anal sphincters preserved their integrity, as did the genital functions.

In the presence of these symptoms and their evolution there could be no hesitation in diagnosing the case as one of peripheral neurotabes. Professor Dejerine prescribed a tonic treatment and gave a favorable prognosis. When seen by him, seven weeks later, the troubles of locomotion and Romberg's sign had completely disappeared.. The patient could walk with closed eyes, and the patellar reflex had returned on both sides, being distinct, though feeble. The disturbances of sensibility had disappeared except in the toes and extremities of the fingers, where slight anæsthesia and analgesia still persisted.

The theory of infection or intoxication now dominates the pathogeny of peripheral neuritis, and in this instance there is no doubt that the diphtheritic toxin was the causative factor, the case presenting the greatest possible analogy with the case of diphtheritic ataxia reported by Jaccoud in 1864 (*Traité des paraplégies et de l'ataxie du mouvement*, Obs. xv). These cases of curable ataxia depend, according to the author, upon periph-

eral nervous lesions limited to the domain of the sensitive nerves,—Leyden's form of sensitive peripheral neuritis.

The Treatment of Chronic Heart Disease by the Schott Method.—Dr. John F. H. Broadbent discusses this method in the May issue of the *London Practitioner*, and Sir William Broadbent follows with some remarks on its mode of action and indications. As is known, the Schott treatment consists of baths containing various mineral substances and free carbonic-acid gas in solution, and of a series of graduated gentle exercises or gymnastics. The patient begins with a bath containing 1 per cent. of chloride of sodium and 1 per 1000 of chloride of calcium, freed from carbonic-acid gas and at a temperature of 92° to 95° F. (33.3° to 35° C.), lasting from six to eight minutes. As time goes on the proportion of solids and the duration of the bath should gradually be increased and the temperature gradually lowered, until eventually baths containing free carbonic-acid gas and the full amount of mineral constituents are taken.

Dr. Schott believes that the chlorides of sodium and calcium and the carbonic-acid gas passing through the epidermis stimulate the sensory nerve-endings and, by a reflex action on the cardiac nerves and muscle, cause the heart to beat more forcibly and less rapidly. This, however, does not seem sufficient to explain the diminution in size of the heart in cases of cardiac dilatation. It is probable that in such cases the dilatation of the cutaneous vessels, whether by the warmth of the water in the weaker baths or by the action of the salts and bubbles of carbonic-acid gas in the others, causes a lowering of tension in the peripheral circulation; so that the heart has less resistance to contend against. Secondly, the flow of blood to the skin thus determined tends to empty the left ventricle and enable it to contract down more fully and completely on its contents.

Dr. Schott has given directions for the preparation of these artificial Nauheim baths, the essential ingredients of which he considers to be chloride of sodium and chloride of calcium, and, later in the treatment, free carbonic-acid gas. To make the weakest bath, containing about 1 per cent. of chloride of sodium and 1 per 1000 of chloride of calcium, one may take 4 pounds (1.8 kilogrammes) of common salt and one-tenth of that quantity of chloride of calcium to 40 gallons (160 litres) of water. These proportions may be gradually increased, as may seem desirable, up to three times that amount. Ordinary sea-water contains about 2.7 per cent. of chloride of sodium, and is thus nearly as rich in this constituent as the Nauheim waters. It does not, however, contain any chloride of calcium. If the right proportions of this salt were added to the bath, there seems to be no reason why sea-water should not be as efficacious as the Nauheim waters; and it should be superior to an artificially-prepared bath. It could easily be diluted so as to contain 1 per cent. of salt for the commencement of the treatment. For the production of carbonic-acid gas bicarbonate of soda and hydrochloric acid may be used. Thus, for a bath of 40 gallons (160 litres) one may take about 6 ounces (186 grammes) of bicarbonate of soda and 7 ounces (217 grammes) of hydrochloric acid of B. P. strength to begin with. This would leave an excess of alkali. These quantities may be increased accord-

ing as it is thought advisable to increase the proportion of gas in the water; so that five or ten times that amount of each may be used eventually. It is best to dissolve the bicarbonate of soda in the bath first and add the acid a few minutes before the bath is taken, stirring energetically. The evolution of gas will continue some five to fifteen minutes, as it takes some time for all the acid and alkali to come into contact in this volume of water. A pint ($\frac{1}{2}$ litre) of water is said to dissolve 16 grains (1.04 grammes) of carbonic-acid gas. Hence, to saturate 40 gallons (160 litres) of water about $1\frac{1}{2}$ pounds (750 grammes) of bicarbonate of soda and $2\frac{1}{2}$ pounds (1250 grammes) of hydrochloric acid would be required, calculating from the atomic weights; but, as this would be too large a quantity to use for practical purposes, and the gas would be given off too quickly, it would be better, where it is desired to have a large amount of carbonic acid in the water, to make use of cylinders of the compressed gas, and allow it to pass through the water in the quantity desired.

The exercises consist of a series of simple movements of each limb and of the trunk made against slight resistance, so that every muscle of the body, as far as possible, is in turn brought into play. The movements should be made slowly and systematically, and a short interval should be interposed between each. They should be stopped if the patient experience the slightest distress in breathing or palpitation or discomfort of any kind; as soon as he is rested they may again be proceeded with. The resistance to each movement should be slight, and should be made by a trained attendant. The movements consist of flexions, extensions, adductions, abductions, and rotations of each limb in turn, and of flexion, extension, and rotation of the trunk. The following is a description approximately of the various movements and of the order which is usually followed in their exercise:—

The patient stands upright, with his arms by his side, or if too weak he may sit down. Movements of the upper extremities are first practiced, beginning with the exercise of muscles round the shoulder-joint. The attendant stands facing the patient, ready to direct and resist each movement: 1. The arms are abducted from the sides of the body and raised till they are parallel to one another in a vertical position above the head; they are then brought back again in the same way to their original position. 2. The arms are rotated forward till they are on a level with the shoulder, parallel to one another in front of the body; they are then brought back again to the sides of the body. 3. The arms still being straight, the two hands are made to touch in front of the body at the level of the shoulder, and the arms are then moved outward till they are as widely separated as possible, making with the body the form of a cross; they are then brought back again in the same way. 4. Movements of internal and external rotation at the shoulder-joint are next practiced. 5. The hands being brought on a level with and close to the shoulders, they are pushed forward till the arms are straight and parallel in front of the body at the shoulder-level; they are then brought back again. 6. The forearm is flexed and then extended at the elbow-joint. 7. The forearm is pronated and then supinated. 8. The wrist and

each of the fingers and the thumb are flexed and extended alternately, each in their turn. 9. The body is bent forward from the erect position, as in making a deep bow, and is then gradually extended again till the erect position is again attained. 10. The feet remaining fixed, the trunk is rotated first to the right and back again, and then to the left and back in the same way. 11. Flexion at the hip-joint of each limb in turn is made till it is raised as nearly as possible to an horizontal position in front of the body, the knee being kept straight; the limb is then brought back again to its original position. 12. Extension is next made till the leg is raised as far as possible behind the body; it is then brought back again. 13. Each leg is then abducted and then adducted in turn. 14. External and internal rotation of each lower extremity at the hip-joint is performed. 15. Next, in a similar fashion, movements of flexion and extension at the knee-joint are made, and movements of flexion and extension and of inversion and eversion of the foot may be performed.

No movement should be repeated except after an interval, the object of the exercises being to bring consecutively into gentle action each group of muscles in the body as far as possible. The resistance to the movements is made by the attendant taking hold of the limb which is being moved, and gently opposing its movement.

The results of the exercises are similar to those produced by the baths on the circulation and heart. The pulse-frequency is diminished; its volume and force are increased. The area of cardiac dullness in cases of cardiac dilatation is diminished and the size of the liver reduced. Dr. Schott's theory is that, as a result of each bath or series of exercises, the heart is stimulated as the result of a reflex process, so that its contractions become more complete and more forcible; and that, as a result of this frequent stimulation and more powerful action, the heart muscle undergoes hypertrophy, till at length the heart, in cases of valvular disease, becomes competent to cope with the extra work imposed on it, or, in cases of dilatation from debility or other causes, recovers from its atonic condition by the improvement in the quality of its muscular coats.

Cases which are likely to derive most benefit from this treatment are: cardiac dilatation due to overwork or mental worry; mitral disease where the right ventricle is beginning to give way and compensation threatens to break down. In adherent pericardium with symptoms of cardiac embarrassment it should be tried. Cases of aortic incompetence are unsuitable unless symptoms of right-ventricle failure have supervened. Cases of aortic aneurism are unsuitable, as the sudden and frequent changes in the blood-pressure can but do harm. In true angina pectoris this treatment must be practiced, if at all, only with the greatest caution. It may be of service in relieving the embarrassment of the heart by vascular dilatation, and thus act like nitrite of amyl or nitroglycerin; but there is a risk of syncopal attacks in which a fatal issue might result. In cases of fatty heart—that is, fatty infiltration, not fatty degeneration—accompanying general obesity this treatment should be beneficial, and is not attended with danger if carefully carried out.

Deaths Following the Injection of Antitoxin.—A young lady of Brooklyn, who was treated for diphtheria with antitoxin, died lately, and DR. JOHN M. CLAYLAND, the coroner's physician, who made a post-mortem examination, reported as follows: "Puncture on the left side of the abdomen, not penetrating the cavity; brain congested; lungs normal; blood fluid; left heart empty, right heart containing a small amount of fluid blood; liver and kidneys congested, especially the latter. No œdema. Larynx normal. The fauces contained diphtheritic false membrane. Cause of death, convulsion due to the injection of diphtheria antitoxin." On the other hand, DR. WILSON, the Chief Bacteriologist to the Brooklyn Board of Health, has presented an official report, in which he says: "Speculative theories may be advanced as to the cause of death in this case, the true cause not having yet been determined; but my experiments, conforming as nearly as possible to the actual condition, demonstrate that it was not inherent in the antitoxin." DR. WILLIAM H. PARK, of the Bacteriological Department of the New York Board of Health, has also reported to the following effect: "My experience led me to express the opinion that the unfortunate results which followed its administration in this specified case cannot be attributed in any way to the antitoxin which was employed." It is to be hoped that the fullest possible details of this case will be published.

A case of death following a preventive injection of antitoxin is reported by DR. AXEL JOHANESSEN to the Medical Society of Christiania. A boy aged 2 years, suffering from spastic spinal paralysis, received an injection of one-fourth of a bottle of Behring's serum (600 units) on December 9th. On the four following days he had sharp diarrhœa, but there was no rise of temperature and no albuminuria. On the 14th there were traces of albumin and indican; the temperature was 103° F. (39.5° C.), and there were infiltration and redness at the site of puncture (under the right clavicle). From the 15th to the 18th the child's condition remained much the same; an incision at the site of puncture gave issue to no pus. Death took place on the 19th. On post-mortem examination no trace of suppuration was found in the infiltrated area about the seat of puncture. The liver was pale; the spleen large and firm; the kidneys rather pale; the intestine dilated; the peritoneum injected, its mucous membrane stained with grayish-black spots, and Peyer's patches were injected and infiltrated. On bacteriological examination streptococci were found. Three other children received preventive injections of the same serum at the same time without ill effect.

In the Hungarian journal *Gyógyáaszat*, No. 5, DR. ALFÖLDI, of Pancsova, relates the case of a girl, aged 3 years, who received a preventive injection of 2 cubic centimetres (31 minims) of Behring's serum (100 units) on January 16th. This was followed by depression and loss of appetite. On January 18th the temperature rose to over 104° F. (40° C.); the child complained of pains in the loins, and there was considerable albuminuria. On the 19th petechiæ appeared over the whole body, and on the 20th the child died.—*British Medical Journal*, May 4, 1895.

A Quick Method for the Filtration of a Small Quantity of Urine.—According to DR. LOUIS FAUGÈRES BISHOP, of New York, for a long time it

has been a problem to know how, with the apparatus usually at hand, to obtain quickly and easily a small quantity of clear urine from a cloudy specimen in order to make the usual test for albumin. (*Boston Medical and Surgical Journal*, April 25, 1895.) The following plan has proved extremely easy and satisfactory in his hands: A small quantity of the cloudy urine is placed in a test-tube, and the mouth of the test-tube plugged with cotton with a moderate degree of firmness. A second test-tube is placed with its mouth to the first. The position of the tubes is now reversed so that the one with the urine is bottom upward. The upper tube is now carefully and gently heated over the flame of a Bunsen burner or an alcohol-flame, and the expansion of the air above the urine immediately forces it through the cotton plug, and the filtered urine collects in the lower tube.

Airol.—This new topical agent is a basic gallate of bismuth in which one molecule of iodine is replaced by a molecule of hydroxyl. According to FAHM (*Corrbl. für Schweiz. Aerz.*, April 15, 1895) it is a siccative of the first order, giving up its iodine readily and without the disagreeable odor of iodoform. He has used it for more than a year in numerous cases without observing any untoward symptoms.

Recent Suggestions in Therapeutics.

Aseptic Catgut.—Wind commercial surgical catgut on a glass spool, not too tightly, and soak for two days in a mixture of equal parts of *alcohol* and *ether*, to thoroughly remove the grease. Rinse in *alcohol* for a few moments, and place in a small jar, with a tightly-fitting cover, containing enough of a mixture of equal parts of *formalin* and *alcohol* to submerge the catgut. After several days remove the catgut and wash out the *formalin* by soaking it several times in fresh *alcohol*, or, preferably, by boiling it for half an hour in normal *saline solution*. Place it in *alcohol* for preservation. (R. H. CUNNINGHAM, *New York Medical Journal*, April 20, 1895.)

Bread Substitute for Diabetic Patients.—Mix 2 ounces (62 grammes) of desiccated cocoa-nut powder with a little water containing a small quantity of German yeast. Make the mass into a sort of paste, and put in a warm place for half an hour or longer. The small amount of sugar contained in the cocoa-nut is almost entirely decomposed by the fermentation produced by the yeast, and the cocoa-nut paste becomes spongy. Add 2 ounces (62 grammes) of aleuronat, one egg beaten, and a small quantity of water, to which a little saccharin has been dissolved, and mix well until a dough is formed. Divide into cakes and bake in a moderate oven for twenty or thirty minutes. Aleuronat is a yellowish powder containing 80 to 90 per cent. of vegetable albumin and only 7 per cent. of carbohydrates. It has been strongly recommended by Professor Ebstein for diabetic patients, but, except by the

Bread Substitute for Diabetic Patients (*continued*).
foregoing method, is difficult to prepare for diabetic food. (R. T. WILLIAMSON, *British Medical Journal*, April 27, 1895.)

Bronchial Adenopathy.—Each morning a wineglassful of Mont Dore or other sulphurated water, fasting, with a little warm milk; *codliver-oil;* 0.001 to 0.002 gramme ($\frac{1}{64}$ to $\frac{1}{32}$ grain) of *sodium arseniate* daily at meal-time, followed in fifteen days by *phosphates. Tar-water* or *terpine.* As calmatives, 2 to 3 drops of *belladonna tincture* and the same quantity of *alcoholic extract of aconite-root*, and *syrup of codeine.* Revulsion of the affected area with *iodine* or *croton-oil.* If possible, a season at a sulphur springs to complete the cure. (JULES SIMON, *Bull. gén. de Thér.*, April 30, 1895.)

Empyema.—Points in surgical treatment: Absolute certainty of diagnosis by an exploratory puncture with an aseptic needle; use of a single aspiration in children, followed, in the event of a re-accumulation, by open incision and drainage; no justification for aspiration in adults, except as a mere preliminary to pleurotomy; the performance of pleurotomy in all recent cases, excluding only the employment of aspiration as an initial procedure in children; avoidance of general anæsthesia when practicable; a single opening for drainage, not located in the most dependent portion of the chest; double drainage-tubes to extend but slightly within the cavity; the resection of a small portion of a single rib in case of a fetid discharge or of marked approximation of the ribs; no irrigation of the cavity, unless in the presence of considerable fœtor, the irrigating solutions to be introduced slowly, of proper temperature, and non-poisonous in nature; observance of scrupulous asepsis during each dressing from the beginning to the end of the case; adoption of multiple rib-resection in the event of an unduly prolonged continuance of the pus-cavity; number of ribs resected and size of section to correspond with the depth and extent of the cavity; exceedingly rare justification for the employment of complete thoracoplasty. (S. G. BONNEY, *Boston Medical and Surgical Journal*, April 18, 1895.)

Emulsion of Castor-Oil.—℞ *Olei ricini*, 1 ounce (31 grammes); *gum acaciæ*, ½ ounce (16 grammes); *elixir saccharin.*, 20 minims (1.3 grammes); *olei amygdalæ*, 2 minims (0.13 gramme); *olei carui*, 2 minims (0.13 gramme); *aq. destill.*, ad 2 fluidounces (62 grammes). Mix. Dissolve the gum in the water, add the oil gradually, and lastly the flavoring. (*Practitioner*, May, 1895.)

Gingivitis of Smokers.—℞ *Salol*, 15 grains (1 gramme); *tinct. cachou.*, 1 fluidrachm (4 grammes); *spirit. menth. pip.*, ad 4 fluidounces (124 grammes). M. ft. lotio. A teaspoonful in half a tumbler of tepid water. (*Practitioner*, May, 1895.)

Impacted Cerumen.—When the impaction is hard, dry, and adherent, and injections of lukewarm water fail, use the following: *Sodium carbonate*, 0.50 gramme (7¾ grains); *glycerin*, *water*, each 5 grammes (1¼

fluidrachms). Drop 10 drops into the ear, and let it remain 10 minutes. Renew the injections of warm water in two or three days, which will generally suffice for the removal of the body. Do not use the curette or stylet except to slightly displace the mass and permit the jet of fluid to surround it. Sometimes an oily solution of 2-per-cent. *salicylic acid* may be necessary, followed by injections of *alkaline water*. When the cerumen has been removed, close the meatus with cotton for from twenty-four to forty-eight hours. (COURTADE, *Manuel pratique du traitement des maladies de l'Oreille.* Paris: Maloine.)

Infantile Diarrhœa.—For children under 1 year: *Antipyrin*, 0.50 gramme (7¾ grains); *simple syrup*, 50 grammes (1½ fluidounces); *water*, 50 grammes (1½ fluidounces). One teaspoonful every two hours several minutes before nursing. Over 1 year add 0.50 gramme (7¾ grains) of *antipyrin* for each year of age. Useful in all cases not due to a toxic cause. (SAINT-PHILIPPE, *Lyon Médical*, May 5, 1895.)

Psoriasis.—Give a *sulphur* bath of three-fourths hour in length, rubbing vigorously with soap. Spread over the affected areas a mixture containing *oil of cade*, 10 grammes (2½ drachms); ordinary *collodion*, 20 grammes (5 drachms). (FOURNIER, *Jour. des Mal. Cut. et Syph.*, March, 1895.)

Rectal Resection in the Female—Vaginal Method.—Plug the rectum with antiseptic gauze and disinfect the vagina thoroughly. Incise the posterior vaginal wall and separate it from the diseased gut. Incise the perineum in the middle line, and isolate, ligature, and divide the rectum below the seat of disease. Draw the upper and cancerous portion of the gut through the vaginal wound and excise it. The advantages of the method are that there is but little hæmorrhage, the diseased parts can be freely exposed, an opening in the peritoneum can be easily dealt with, and enlarged glands in the mesorectum can easily be removed. (REHN, *Cent. für Chir.*, No. 10, 1895.)

Scarlatina.—*Regular Form:* Place the patient in a large, airy room, of moderate temperature. Give only milk as nourishment, with acid drinks. Give a cold bath daily of a quarter of an hour in length, and wrap the patient immediately afterward in a woolen blanket. Rinse the mouth three times daily with the following solution: *Thymol*, 0.25 gramme (4 grains); *carbolic acid*, 1 gramme (15½ minims); *tincture of eucalyptus*, 10 grammes (2½ fluidrachms); *water*, 1000 grammes (32 fluidounces); *alcohol* at 90°, q. s. Paint the throat every three hours with the following: *Resorcin*, 1 gramme (15½ grains); *glycerin*, 20 grammes (5 drachms); *rose-water*, 80 grammes (2½ fluidounces). If the fever is high, give a cachet, morning and evening, containing *antipyrin*, 0.50 gramme (7¾ grains); *sulphate of quinine*, 0.25 gramme (4 grains).

Malignant Form: Plunge the patient in a bath of 18° to 25° C. (65° to 77° F.) for ten minutes three times daily, omitting only when there is cardiac weakness or danger of collapse. Give every hour a table-

Scarlatina (*continued*).

spoonful of the following potion: *Caffeine*, 1 gramme (15½ grains); *sodium salicylate*, 3 grammes (46 grains); *rum*, 40 grammes (1¼ fluidounces); *simple syrup*, 30 grammes (1 fluidounce); *distilled water*, 50 grammes (1½ fluidounces). Insure antisepsis of the mouth and paint the throat as before mentioned. Wrap the swollen joints in cotton and rub them with *baume tranquille* (*balsam tranquillans*, Fr. Cod.).

Convalescence: Keep the patient in bed at least eight days after the disappearance of the eruption, and give only light food until albuminuria has disappeared. Keep up a rigorous milk diet if the urine is albuminous. Give a lukewarm bath daily to aid desquamation and rub the body with *carbolized oil.* At the principal meal order a teaspoonful of *iodo-tannic wine.*

Prophylaxis: Maintain rigorous isolation until the end of desquamation, at least forty days. Wash the hands after each examination of the patient and rinse the mouth frequently with *boric-acid solution.* See that all objects touched by him are disinfected and that soiled linen is boiled. The floor of the room can be cleaned with sawdust impregnated with a solution containing *sulphate of copper*, 12 grammes (3¼ drachms); *water*, 1000 grammes (1 quart). (MALBEC, *Tribune Méd.*, May 1, 1895.)

Monographs Received.

The editor acknowledges, with thanks, the receipt of the following monographs:—

Le Phénol Sulforiciné dans la Tuberculose Laryngée, par **Albert Ruault**, Paris, 1895.——Transactions of the Sixteenth Annual Meeting of the American Laryngological Association, at Washington, May 30, 1894.——The Operative Treatment of Hernia, with a Report of Two Hundred Cases, by **William B. Coley**, New York, 1895.——Société Française de Laryngologie, d'Otologie, et de Rhinologie. Rapports de MM. les Drs. **Rauge, Miot, et Herck.** Réunion de Mai, 1895. Paris.——Treatment of Laryngeal Tuberculosis by the Application and Submucous Injection of Creasote, by **Walter F. Chappell**, New York, 1895.——Notes from Country Surgical Practice, by **G. G. Cottam**, Rock Rapids, Ia.——Du Traitement Prophylactique de l'Ophtalmie des Nouveau-Nés par le Nitrate d'Argent en Solution Faible, par **P. Budin**, Paris, 1895.——A Bacteriological Study of Oysters, by **Charles J. Foote**, 1895.——La Contagion du Cancer, par **O. Guelliot**, Reims, 1895.——Report of a Case of Pathological Separation of the Lower Epiphysis of the Femur, by **A. H. Meisenbach**, St. Louis.——Statistique du Service d'Accouchements de la Charité, par **L. Merle** et **C. Henault**, Paris, 1895.——Annual Report of the Medical Work in Connection with the Peking Mission, 1894.——Étude sur la Pathogénie de la Maladie de Basedow, par **A. Bienfait**, Liege, 1895.——Leucorrhœa: its Causes, Varieties, and Treatment, by **Thomas More-Madden**, Dublin, 1895.——Eine neue Method der Diagnose und Therapie gewisser Magenkrankheiten und bakteriologische Studien bei denselben, von **Fenton B. Turck**, Chicago, 1895.——Compte Rendu de la Société des Ambulances Urbaines de Bordeaux, 1894.——Inflammation and Microbes, by **John D. Kales**, Chicago, 1895.——Modern Surgery of the Pelvic Floor in Women, by **George H. Kirwan**, Wilkesbarre, Pa., 1895.——Versammlung der Vorstände von Lymphgewinnungsanstalten in Deutschland, Oesterreich-Ungarn, und de Schweizer, von Dr. **Chalybaus**, Dresden, 1895.——Early Diagnosis of Carcinoma of the Stomach, with the Bacteriology of the Stomach-Contents, by **Fenton B. Turck**, 1895.

☞ ***Any journals, exchanges, reprints, monographs, or books not sent directly to the editorial office, 28 rue de Madrid, Paris, will not receive attention either in the "Annual" or the "Universal Medical Journal."***

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(End of Editorial Department of Journal for June, 1895.)

RATIONAL THERAPEUTICS OF CHOLERA INFANTUM.

By GUSTAVUS BLECH, M.D., St. Louis.

No strict rules can be given for the treatment of disease. It is for this reason that so many physicians say we do not treat a disease, but we treat an individual. True enough, we treat the individual, but what we have most of all to consider is the disease. The individual will dictate us alterations and modifications in our treatment.

A general plan of treatment may be outlined, however, and I will try to do so in regard to one of the most fatal diseases of babyhood,—cholera infantum. There is a certain philosophy in therapeutics which I would frame in the three following rules: First, remove, if possible, the disturbing causes; second, treat symptoms which *per se* are liable to endanger the life of the patient; and third, sustain vitality. As said before, the therapeutics, which is based upon the ætiology and pathology of a given case, is the only one to be employed.

Now, the ætiology of cholera infantum is not so obscure as asserted by a good many authors. Whether or not of microbic origin, one thing is sure—it is due to a chemical decomposition of food, causing an inflammatory condition of the digestive and alimentary canal.

As soon as called to a case of cholera infantum, prohibit for the first day any food whatever. Mothers have no right to nurse the little patient, either. Strict instructions must be given in that direction, because the timid mothers are often inclined to quiet the crying babies by putting them to the breast. Remedies are of very little value. Beginning with calomel, salol, and all the newer antiseptics, finishing with subnitrate of bismuth—they have all proved a failure, for none of them work quickly enough.

The treatment as outlined by Dr. Elmer Lee, of Chicago, in his cases of typhoid fever, proved a success in my hands during last summer, and under this treatment I have lost only one patient out of twenty-three, while the monuments of my skill exercised during the year 1893 are decorating the cemeteries of the State of Connecticut. So far as I knew, the best antiseptic (which has also a strong tendency to reduce local inflammation) was peroxide of hydrogen (medicinal) until hydrozone was used by me. Hydrozone being twice as strong as Marchand's peroxide of hydrogen (for economical reasons), the latter drug is preferred by me. This remedy can be administered internally as well as externally.

I add a tablespoonful of hydrozone to a pint of water for washing out the stomach. The vomiting ceases after the first washing, as a rule. If necessary, this procedure can be repeated. If the vital power of the little patient is not too low it can produce no harm. But in every case, no matter how far advanced, I do not omit an irrigation of the bowels, for which purpose I use a soft rubber catheter attached to a common bulb-syringe. The catheter is introduced as high in the colon as possible. It is unnecessary to say that the water must first be sterilized. I do not agree with Dr. Lee in using hot soap-water. On the contrary, I use cold water, and add to each quart about two ounces of hydrozone. The improvement after the first or second irrigation is marked. If necessary, these irrigations can be repeated every two hours.

Among other remedies there are only two to be employed, morphine and strychnine. Both ought to be administered hypodermically. Their indication is too well known and they are about all we need. No antipyretics should be given. If the fever is very high and if the irrigation of the bowels does not reduce it, the whole body should be washed with alcohol. The diet for the next twenty-four hours should be very light indeed. Sweet, strong Russian tea is all I allow. Each individual case will teach us when food can be allowed again. Since the adoption of this mode of treatment I have met with the most remarkable success, and no honest practitioner should refuse it a trial.—*New York Medical Journal.*

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Selections from Society Proceedings.

AUSTRIA.

DEUTSCHE KONGRESS FÜR GYNÆKOLOGIE, VIENNA.

Rupture of the Uterus.—HERR FRITSCH, of Bonn, stated that the prophylactic treatment of rupture of the uterus in cases of contracted pelvis consisted in placing the parturient on the side corresponding to the most distended portion of the genital apparatus. Gentle effort should be made to cause the head to descend, and, if rupture appear imminent, labor should be terminated at any cost. The method of choice should be one which takes into account the narrowness of the pelvis. In head presentations perforation gives the best results for the mother; in oblique position, version should be attempted under anæsthesia only when the child is living. If rupture have occurred and the child is in the abdominal cavity, laparotomy should be performed. If the infant have only partly passed into the abdomen, and extraction by the vagina seems possible, it should be attempted.

As regards hæmorrhage, the only means of definitely arresting it when due to rupture is by suture after opening of the abdomen. Its origin is not so much in the uterus as in the pelvic tissue, outside the uterus,—that is, in the parametrium. After laparotomy and evacuation of the blood-clots in the pelvic cavity, it is frequently found that the peritoneum is but slightly involved, but that the rupture occupies the entire thickness of the broad ligament. In such cases the only way of securing hæmostasis is by placing a number of wide, deep sutures in and upon the broad ligament.

When the physician is called in a case of rupture five or six hours after labor,—that is, when the first danger is passed and hæmorrhage is arrested, but there is fear of infection, as shown by the swollen abdomen and heightened temperature,—Herr Fritsch is in favor of the expectant plan, and advises absolute rest, small doses of opium to retard fæcal movements, and

emptying the bladder with the catheter, but no vaginal or uterine injections, and still less washing of the peritoneum through the rupture.

Vaginal Hysterectomy.—HERR VEIT, of Berlin, gave the following indications and contra-indications for this operation: 1. When the fibroid is voluminous and growing rapidly the vaginal method is contra-indicated. 2. If malignant degeneration is suspected and the tumor is small, the vaginal method is indicated; if large, the abdominal method. 3. In impacted fibroids the vaginal method is alone indicated. 4. The principal indication for vaginal operation is abundant metrorrhagia. The size of the tumor is of less importance, though it should be ascertained if it is small enough to pass the pelvic strait; if not, laparotomy should be performed. The operation of morcellation is not so easy as is claimed. In the majority of cases when there is great metrorrhagia a fibroid is present, either submucous or developed in the neighborhood of the mucous membrane. These tumors can easily be reduced in the uterine cavity by the bimanual method, the cervix being previously cut so as to permit of their enucleation. In all vaginal operations section should be as nearly median as possible.

FRANCE.

ACADÉMIE DE MÉDECINE.

Treatment of Diabetes.—M. ALBERT ROBIN gave his plan for the treatment for this disease, dividing it into three periods. In the first period he gives antipyrin—which diminishes oxidation, especially of nitrogenous substances—for five days in succession, combining 1 gramme (15½ grains) of the drug with 0.50 gramme (7¾ grains) of sodium bicarbonate, before meals. The dose should not exceed 2 or 3 grammes (31 to 46 grains) daily for four or five days. The first contra-indication is albuminuria, unless there should be marked glycosuria, when antipyrin should be given only for three days. In pancreatic diabetes and in very severe cases the remedy is of no value. If during this period of treatment the quantity and specific gravity of the urine diminish simultaneously, he continues the drug; but if the specific gravity increase and the quantity diminish, he immediately discontinues its use, as it will prove of no value. He sometimes adds codliver-oil and an alkaline mineral water, as well as potassium salts, giving 3 to 5 grammes (¾ to 1¼ drachms) of Rochelle salts at one meal, and a bottle of Vichy water at the other. In the second period of treatment he uses sulphate of quinine, which, as is known, diminishes the destruction of nitrogenous substances, diminishes oxidation, and lessens the quantity of O_2 absorbed and the quantity of CO eliminated. Arsenic also slackens oxidation, lessens nitrogenous changes, especially in the organs rich in phosphorus. Alkalines and codeine act in the same way, diminishing the urea and uric acid, and retarding nutrition. He first gives 0.40 gramme (6 grains) of sulphate of quinine twice daily for five days, discontinues it for four days, and resumes it for five days. At the same time he administers the following cachet: Sodium arseniate, 0.001 to 0.003 gramme ($\frac{1}{64}$ to $\frac{1}{22}$ grain); lithium carbon-

ate, 0.10 to 0.15 gramme ($1\frac{3}{4}$ to $2\frac{1}{4}$ grains); codeine, 0.02 to 0.05 gramme ($\frac{1}{3}$ to $\frac{7}{8}$ grain); theriacal powder, 0.25 gramme (4 grains); extract of quinquina, 0.25 gramme (4 grains). Two daily for two days, three daily for three days, and four for ten days. The patients at the same time drink 1 litre (quart) of water daily containing 8 grammes (2 drachms) of sodium bicarbonate. This period of treatment covers fifteen days. During the third period he has recourse to opiates, which lessen nitrogenous and total disassimilation, and lessen oxidation by acting on the nervous system. Valerian has such an action, and also favorably influences polyuria, azoturia, and glycosuria. The bromides modify nitrogenous oxidation, but the earthy phosphates also diminish, showing a powerful action on the cerebral functions. He used the following formula: Extract of belladonna, 0.005 gramme ($\frac{1}{12}$ grain); extract of valerian, 0.10 gramme ($1\frac{3}{4}$ grains); extract of opium, 0.01 gramme ($\frac{1}{6}$ grain); powder of quinquina, q. s. to make one pill, to be given every six hours for two days, one every four hours for two days, and one every three hours for two days, and one every eight hours for two days.

Given a typical case of diabetes, Professor Robin begins by putting him on the classical diet prescribed by Bouchardat for from five to eight days. The sugar is then measured and the first period of treatment begun. A second analysis is then made, and, if the sugar have disappeared, a severe diet is alone instituted; but if it have simply diminished, he begins the second period of treatment, and follows with the third. Whether the sugar has or has not disappeared, he then ceases all medication for a month and keeps the patient on a diet, resuming the treatment again until the sugar finally disappears. He has thus treated 100 severe cases, in which the amount of sugar exceeded 100 grammes ($3\frac{1}{4}$ ounces) in twenty-four hours. Of these there were 25 definite recoveries, 25 in which recovery is not yet definite, 32 cases of considerable and permanent improvement, and 18 cases in which the results were negative or only temporary.

Société de Chirurgie.

A New Method of Hysterectomy.—M. Richelot has devised an original and improved method of performing this operation. He claims for his procedure great advantages over the current ones, which are long and laborious, and over the quicker ones sometimes employed, which are frequently attended with danger. The principal advantage of his method lies in the complete absence of ligatures and sutures, forcipressure only being used. A scalpel, a dissecting-forceps, a long and a short hæmostatic forceps, and finally two long Richelot forceps, provided with a long "bite," comprises the armamentarium necessary. The patient is placed on her back and the operator takes his station between the separated limbs. The vagina is first thoroughly disinfected, for in the course of the operation the surgeon's hand passes alternately into that canal and the abdomen The usual abdominal incision being made, the uterus is enucleated and laid on the abdomen, covering the lower angle of the operation wound. When fibro-

mata occupy the lower segment of the organ the usual fragmentation is at once practiced; when, however, they are interstitial they are left untouched, and the operation is proceeded with as follows: An interior peritoneal flap is fashioned by means of an incision across the anterior surface of the uterus, extending from one broad ligament to the other. The broad ligaments are thus liberated and thrown downward over the bladder. The left index finger is introduced into the vagina, and the anterior *cul-de-sac* is incised with a large pair of scissors, the discission of the vagina being pushed nearly as far as the sides of the os. Then, leaving the uterus *in situ*, the broad ligament on one side is seized by the hand quite close to the uterus, an opening in the posterior *cul-de-sac* is made with the point of the scissors, and through this orifice is passed, *per vaginam*, the posterior limb of Richelot's forceps, the anterior limb being thrust through the corresponding hole in the anterior *cul-de-sac*. The forceps is then thrust from the vagina from below upward, and, guided by the hand holding the broad ligament, is placed on that ligament. The same manœuvre is practiced on the other side by means of the second pair of Richelot's forceps, both ligaments being seized by the forceps and liberated from their extreme attachments. The uterus now hangs only to the posterior *cul-de-sac*, which is in its turn divided with a few snips of the scissors, and, as this section gives rise to hæmorrhage, three hæmostatic forceps are placed in position. A plug of iodoform gauze is inserted into the upper part of the vagina, none being placed in the abdomen. The abdominal incision is sutured and the operation is over. Of five hysterectomies thus practiced by M. Richelot, four being for fibromata and one for cancer, the four first mentioned were successful. The duration of the operation varies from thirty to thirty-five minutes, and no complications need be feared during the healing process.—*Lancet*, May 4, 1895.

ACADÉMIE DES SCIENCES.

Alleged Cure of Two Cases of Cancer by Serotherapy.—Those pioneers in serum therapeutics, MM. RICHET and HÉRICOURT, brought before the notice of the academy the encouraging results said to have been yielded by the application of this method in the treatment of malignant disease. On February 9, 1895, M. Reclus removed an osteosarcoma of the leg. This tumor was crushed and mixed with a little water, and the resulting liquid, after having been filtered through linen, was employed to inoculate a donkey and two dogs. The inoculation produced no reactionary symptoms; after five, seven, and fourteen days, respectively, the animals were bled and the serum utilized in the treatment of two cases. The first was a woman for whom Professor Terrier had, in October, 1894, removed a growth presenting the appearance of a fibrosarcoma, which, having attained the size of an orange since it was first noticed (eight months earlier), was adherent to the sixth, seventh, and eighth ribs, the integuments not being involved. In February, 1895, the growth had re-appeared and was as large as a hazel-nut; a month later, March 7th, it had reached the volume of a small orange. Daily doses of 3 cubic centimetres (46 minims) of the serum were injected

during forty days into the areolar tissue surrounding the growth. The tumor began to shrink on March 25th, and the shrinkage became more and more marked as time went on. At present all that remains of the neoplasm is an indurated *plaque* whose contour is difficult to delimit and whose volume is less than a third of the original growth. The woman's general health has, moreover, greatly improved, and she has put on flesh to an appreciable extent. The second patient was a man aged 44 years, admitted on March 27th, under M. Reclus, to the Pitié Hospital for a tumor of the epigastric region the size of a large orange, and diagnosed as cancer of the stomach. The idea of surgical intervention having been rejected, serotherapeutic treatment was commenced on April 6th by the injection of 4 cubic centimetres (1 fluidrachm). Between that date and April 24th he received 64 cubic centimetres (2 fluidounces). An early improvement in the general condition was noticed, the body-weight having increased from 57 kilos (125½ pounds) on April 10th to 58 kilos ($127\frac{6}{10}$ pounds) on the 16th and 60 kilos (132 pounds) on the 23d. From April 10th the volume of the growth had diminished, and this atrophic process continued, so that ten days later the tumor could no longer, as hitherto, be felt as a projecting isolated mass. Palpation gave only the sensation of a resisting surface,—a vague thickening deeply situated and difficult to circumscribe. The extraordinary success attending the treatment in this second case leads MM. Richet and Héricourt to ask, *par un excès de prudence*, if there were not an error of diagnosis; but in Professor Terrier's case there would seem to be no reasonable doubt that a sarcoma which had recurred in the same spot was, thanks to the injections, reduced to one-third of its original size, with manifest advantage to the general health of the patient. Most clinicians would, thus early, hesitate to echo the jubilant note of the discoverers who proclaim that the patient is *cured*. The growth is still present, although apparently dormant. This cautious reserve does not, however, lessen the credit due the two patient workers who have done so much for serotherapy. —*Lancet*, May 11, 1895.

SOCIÉTÉ FRANÇAISE DE DERMATOLOGIE ET DE SYPHILIGRAPHIE.

Baccelli's Treatment of Syphilis.—Especial interest was manifested in this subject at the annual meeting of the society, the discussion being opened after the reading of a paper by DR. ADADIE, of Paris (*Brit. Jour. of Derm.*, June, 1895), who lauds intra-venous mercurial injections in every case of syphilis. He employs a 1-per-cent. solution of cyanide of mercury and a syringe made entirely of glass, which can be perfectly sterilized, and which contains 1 gramme (15½ minims) of liquid (0.01 gramme—⅙ grain—of cyanide of mercury). The arm being ligatured about the middle with a handkerchief, the vessels of the forearm and elbow swell, when a vein is selected and the part to be pricked is cleansed and sterilized. The needle of the syringe is passed through the flame and then introduced gently in an oblique direction from the epidermis into the cavity of the projecting vein, almost horizontally to the epidermis and following the axis of the vessel. As soon as the cavity of the vein is struck—and this is easily felt—the

needle is arrested, the handkerchief removed, and the piston slowly pushed down. The syringe is then withdrawn and a light antiseptic dressing, fixed with collodion, is applied. The patients appear to feel nothing, and are able to go at once to their work. No redness, swelling, or pain is caused beyond that which results from a simple prick of the skin. Dr. Abadie has never had the slightest accident, though he has administered from 400 to 500 injections. He gives an injection every other day and continues to do so for three weeks; then he stops all treatment for a fortnight, and recommences the series if necessary.

Dr. Wickham, in discussing the method, expresses the opinion that, should any accident occur through want of attention to the smallest detail, it would be a serious matter, bringing about death through the introduction of air into the veins, or by generalized infection, phlebitis, etc. He therefore proposes to limit these intra-venous injections, as well as all subcutaneous injections, to serious and obstinate cases, and thus gradually build up experience. When a certain number of observations shall have been made, and all the minutest details of the operations have been mastered, the method by intra-venous injection may be applied to those severe cases in which subcutaneous injections are now regarded by all as being suitable. Thus, experience will be multiplied, and if the method prove always satisfactory it may be extended to the treatment of all forms of syphilis, and from the very beginning, which would be ideal.

GERMANY.

Gesellschaft der Aerzte in Munich.

Cancer and its Serum Therapy.—A spirited debate on this subject was aroused by the communication of Emmerich and Scholl, of Munich, in regard to the curative effects of erysipelatous toxins in cancer. These authors inoculated sheep with cultures of cocci of erysipelas and abstracted blood when they were in a stage of convalescence. They passed this blood through Chamberland filters to remove the cocci and then injected from 1 to 4 cubic centimetres ($\frac{1}{4}$ to 1 fluidrachm) daily into the tumors when small, and from 10 to 25 cubic centimetres ($2\frac{1}{2}$ to $6\frac{1}{2}$ fluidrachms) when large. They thus treated three cases of recurrent and two cases of primary cancer of the breast, a sarcoma of the shoulder, and an epithelioma of the angle of the eye. In nearly all the cases they observed an amelioration of the general condition and a diminution in the size of the tumor.

Angerer, in whose service Emmerich and Scholl made their experiments, states that their statistics are not exact, since they omit three failures and include among the cures a case of carcinoma now ulcerating and a case of cancerous cachexia in which death occurred in three weeks.

Professor Bruns tried the serum furnished by Emmerich in six cases of undoubted cancer without observing the slightest therapeutic effect or the slightest diminution in the size of the growths. On the other hand, he did observe dyspnœa, cyanosis, marked elevation of temperature, weakening of

the heart's action, and vomiting; and in one case there was even albuminuria, with casts in the urine. He emphasized the danger of these injections and urged caution in their use.

EMMERICH and SCHOLL responded to these criticisms by pleading extenuating circumstances, declaring that the serum was pure when furnished, but had not been properly kept sterile, owing to faulty technique.

PETERSEN reproached the authors for their undue haste in publishing their discovery, and for justifying themselves by invoking the cures of cancer obtained by erysipelatous inoculations by Busch, Fehleisen, Neisser, Coley, and others. Examination of these sources showed that the citations are not correct. Fehleisen says nothing of the ultimate result of his three cases; Neisser's patient died several days after inoculation; Busch, Biedert, and Bruns's cases were not of carcinoma; while Coley observed marked improvement, but no cures, in his cases of carcinoma.

FREYMUTH cited two cases in which a cancer of the tongue was somewhat modified by the injection, but the patient died of cachexia.

ZIMMERMANN alone seemed to be more favorably disposed toward the method. He had seen a cancer of the breast diminish in four days after a total injection of 9 cubic centimetres (2¼ fluidrachms) of the serum. This result he regarded as encouraging and as justifying a further trial of the method.

GREAT BRITAIN.

OBSTETRICAL SOCIETY OF LONDON.

The Development and Normal Structure of the Human Placenta.—DR. EDEN, in a paper on this subject, said that the placenta consisted of two series of structures: one developed from the ovum,—the fœtal placenta; the other developed from the uterus,—the maternal placenta. The fœtal placenta was developed from the external fœtal envelope, or chorion. At the end of the second week the chorion was covered with villi, the reflexa had closed over the ovum, and the tips of the villi were loosely imbedded in it. The fœtal and maternal vessels were thus brought into close relation, and the general arrangement represented a simple type of diffused placenta. The development of the discoidal placenta merely consisted in the specialization of a part of the chorion. The placental chorion consisted of three sets of structures: (1) a covering of epithelium, (2) a connective-tissue stroma, and (3) blood-vessels. The chorionic epithelium consisted of two layers; the superficial layer or trophoblast represented the fœtal epiblast and was the more important of the two. By a process of proliferation buds were formed from the trophoblast which developed into new villi, and the steps of the process were described. The stroma consisted of a delicate reticulum of branching connective-tissue corpuscles, with numerous leucocytes. The meshes of the stroma formed a system of lymphatic channels which were in communication with the capillaries. The vessels of the villi were very large and numerous, and ran, for the most part, immediately beneath the epithelium; this was an arrangement favorable to osmosis. The lym-

phatic system of the stroma could be artificially injected from the capillaries. In uninjected placentæ blood was often found in the stroma, so that the villi appeared to be soaked with blood like a sponge. The maternal placenta was developed from the uterine mucosa. The earliest changes were a continuation of those found in menstruation, for the fertilized ovum was engrafted on the mucosa in its active phase. The development of the decidua consisted of three stages. In the first stage extensive hæmorrhages occurred in the decidua, and decidual cells were formed in large numbers from the connective-tissue corpuscles. These changes were preparatory, and could be found in all parts of the decidua during the first month. In the second stage the chorionic villi invaded the serotina, and the maternal vessels were opened up, thus establishing a circulation through the intervillous spaces. The invasion of the serotina appeared to be the result of the great activity of the trophoblast layer, and the steps of the process were described. The decidual cells also showed great activity in the absorption of blood effused into the serotina. Large lacunæ were formed by the opening up of neighboring vascular and glandular channels. The changes characteristic of this stage were found at the growing margin of the placenta up to the last weeks of gestation. The third stage represented the adult stage of the serotina. All active processes had then ceased, and the serotina had undergone some amount of consolidation and repair. The course of the maternal vessels through the serotina and their openings into the intervillous spaces were described in detail. The intervillous spaces were, according to Dr. Eden, made up (1) of the space existing primarily between the decidua and the chorion, (2) of spaces formed by destruction of decidual tissues, and (3) of glandular and vascular channels opened up in the same way. The circulation through the intervillous spaces was not rapid, the outflow being chiefly promoted by the intermittent contractions of the uterus. The giant-cells so often described in the serotina were really imbedded trophoblastic buds. The fœtal and maternal structures of the placenta were firmly bound together by the attachment of numerous villi to the serotina; the changes occurring at the site of attachment were described. Owing to this firm union, separation of the placenta during labor occurred not between the fœtal and maternal layers, but through the loose cavernous layer of the serotina.—*Lancet*, June 15, 1895.

Royal Medico-Chirurgical Society, London.

Intra-peritoneal Rupture of the Bladder.—Mr. W. J. Walsham read a paper upon this subject, and presented a table of cases of rupture of the bladder treated by suture since 1888, drawn up by Mr. W. Ernest Miles. In 1888 Mr. Walsham read before the society a case of intra-peritoneal rupture of the bladder successfully treated by suture, supplementing the paper with a table of eleven cases, all he could find published, treated in like manner. He now relates a second successful case, and Mr. Miles, late house-surgeon to the Metropolitan Hospital and Radcliffe Infirmary, Oxford, had collected seventeen additional cases in which suture was employed,

making altogether twenty-eight published cases of intra-peritoneal rupture of the bladder treated by suture. The patient, aged 42, was admitted into the Metropolitan Hospital, March 8, 1895, with an intra-peritoneal rupture of the bladder. The diagnosis was established by inflating the bladder with a few cubic inches of air, forced in by two or three compressions of the rubber ball of an ether-freezing microtome. The abdomen at once became tympanitic and the liver-dullness effaced. The rent was closed by fourteen silk Lembert sutures, the pelvic cavity irrigated with perchloride of mercury and boracic lotion, and the abdominal wound sewn up after the bladder had been proved competent by injection with milk. An uninterrupted recovery took place. The value of the inflation and injection tests for ruptured bladder were discussed. The present appeared to be the first case in which the inflation test had actually been put into practice. The conclusions drawn from a single experience were: (1) that the amount of air to be introduced need only be very small, not more than three or four cubic inches, (2) that only very moderate pressure is required for the inflation, (3) that the presence of quite a small amount of free gas in the abdominal cavity is sufficient to establish the diagnosis beyond a doubt, and (4) that the introduction of gas into the abdominal cavity, even in small quantity, is attended by a profound disturbance in the patient's general condition. The disturbance which followed in this case at once passed off on opening the abdomen and allowing the free air to escape. It was suggested, therefore, that the test in future should not be applied till the patient is on the operating-table, so that, should the collapse threaten life, the abdomen can be opened at once. In the after-treatment of the case it was contended that a catheter should not be left in the bladder,—first, because it was not necessary; and, secondly, because of the risk of cystitis and septic infection. Of the 28 cases included in the two tables 11 recovered and 17 died. Of the 11 that recovered, in only 1 was peritonitis present at the time of operation; whilst, conversely, of the 17 that died, in 8, and probably in 9, peritonitis had already set in. The causes of death in the 8 cases in which there was no peritonitis at the time of operation were in 5 shock or hæmorrhage or the two combined, and in 3 peritonitis, the peritonitis in 2 out of the 3 being due to leakage of the rent or giving way of a suture. In no fewer than 4 out of the 28 cases was the bladder found, at the post-mortem examination, to leak. The importance of testing the competency of the bladder by injecting milk or other bland and easily detectable fluid could not, therefore, be too strongly urged.

Mr. Barker thought it improbable such severe symptoms would be due to the introduction of air into the peritoneal cavity. The intra-abdominal pressure was constantly varying in health without any such result. He did not consider the injection of milk a harmless proceeding; he had seen severe cystitis follow its introduction into the bladder, and would prefer some carefully sterilized fluid.

Mr. F. C. Wallis had seen the author's case on admission, and could testify how satisfactorily inflation settled the question of rupture of the bladder, which at first, owing to somewhat indefinite symptoms, appeared a

very open one. He thought the distension of the abdomen accounted for the symptoms following inflation, and suggested that it might be well to perform inflation under an anæsthetic, so as to minimize bad results. He had often used milk in cases of recto-vesical fistula, but never with any evil consequences.

MR. A. M. SHEILD referred to one of the earliest cases of suture of ruptured bladder performed by Mr. T. Holmes with complete success. The most difficult cases to diagnose were those in which the rupture was small; when large there was not so much doubt. In some cases the mucosa of the bladder might be damaged and give rise to hæmaturia without rupture occurring; in illustration of this a case of abdominal injury and suspected rupture of the bladder was quoted in which water was injected into the bladder and distended it. On this ground rupture was negatived, no operation was performed, and the patient recovered. He thought, on the whole, injection with water was the best method of diagnosis. He mentioned Senn's method of injecting hydrogen into the intestine in cases of suspected perforation, and suggested that possibly hydrogen was better than air. He asked the author whether the sutures passed through the whole thickness of the vesical wall. In cases where the sutures passed through the mucous coat calculi might form.

MR. A. A. BOWLBY thought escape of air into the peritoneal cavity quite a sufficient cause for the symptoms following inflation; a similar result occurred in intestinal perforation. A very small quantity of free gas was sufficient to cause disappearance of the hepatic dullness, probably because this was the highest part of the abdominal cavity. He had several times seen a calculous deposit form on sutures which had penetrated the mucous membrane of the bladder.

MR. WALSHAM said that the alarming symptoms were due to the intro duction of air into the peritoneal cavity because (1) they came on directly the inflation was performed, the patient having been, up to that moment, calm and in good condition, and (2) they passed off when the abdomen was opened and the air let out. Theoretically there might be a better fluid than milk for injection, but practically he had found it did not lead to any untoward results. He thought the inflation test might be especially useful in cases where the rupture was very small and where the intestine might block the opening and so prevent the water test from acting. He had taken care not to pass the sutures through the mucous coat.—*British Medical Journal*, June 15, 1895.

UNITED STATES.

AMERICAN MEDICAL ASSOCIATION.

Meeting at Baltimore.

Hydrotherapy in Fevers.—DR. A. H. BURR, of Chicago, gave a general review of the cold bath, showing that its value depended, first, on the physical effect of water as a neural stimulant; second, on the susceptibility of the sympathetic nervous system with its control over the glandular apparatus of the body; third, on the reflex influence on the respirative circu-

lation, metabolism, elimination, and pyrexia. He described an apparatus invented by him for the purpose of giving cold baths. It consists essentially of a rectangular frame which can be laid on the bed. To its sides are fastened tapes from a large rubber sheet, which is sloped down inside the frame and is under the patient. Thereby is formed an improvised tub which will easily hold twenty gallons, and which can be siphoned out when the bath is ended. He bathes according to the full Brand method.

DR. CHARLES G. STOCKTON, of Buffalo, made an earnest plea for the introduction of the Brand method into small communities. He thought that the apparatus devised by Dr. Burr would contribute greatly to this end.

DR. S. S. COHEN, of Philadelphia, thought that sponging on a rubber sheet had the disadvantage of merely collecting small pools of water about the patient. Immersion of the whole body is better. He would consider Dr. Burr's apparatus as next useful to a tub.

DR. ROCHESTER, of Buffalo, called attention to the friction-massage as an essential part of the Brand method.

DR. JAMES TYSON, of Philadelphia, was an advocate of the bath. He had, however, lost some cases where it had been used, death resulting from hæmorrhage and perforation.

DR. J. M. ANDERS, of Philadelphia, believed the use of the bath to be contra-indicated where hæmorrhages occurred; at least, for a time.

The Symptomatology of Irregular, or Atypical, Gout.— DR. JAMES TYSON, of Philadelphia, alluded to the recent work of Roberts, who had shown that the uric acid circulated in the blood in the form of a quadriurate of soda. Local symptoms were probably produced by local deposits, though we might not be able to detect the latter. The symptoms of irregular gout were of the most diverse variety. We might have dyspepsia, lithate deposits in the urine, eczema, muscular pains, deep-seated pains in the tongue, a feeling of crackling about the cervical spine, knotting about the small joints, pain in the back (especially the lumbar regions, in the femoral adductors, and gastrocnemii), articular pains and nodosities; not uncommon also were headaches, pain in the palms of the hands, folliculitis about the nose, scleritis, corneitis and conjunctivitis, pharyngitis, tonsillitis, bronchitis, and asthma; dryness of the tongue and skin; also hæmorrhages into the bladder; in the nervous system were change of temper, capriciousness, melancholia, and insomnia. He would lay special stress upon vesical hæmorrhage, the frequent uric-acid cause of which was not generally known.

He gave the following rules to assist in diagnosis of atypical, or irregular, gout: 1. Uric acidæmia, though it was rarely possible to detect uric acid in the urine with the means at the disposal of the general practitioner. 2. The supervention of an attack of typical gout on the subsidence of other ailments or in alternation therewith. 3. The history of a previous regular attack. 4. Heredity. 5. History of exposure to lead-poisoning. 6. History of the mode of life. 7. High-colored and scanty urine; the relation of gout to lithæmia was a vexed question, but there were no urinary deposits in pure lithæmia. 8. Glycosuria. 9. Chronic interstitial nephritis, the unfortunate result toward which gouty tendencies inevitably lead. 10. The results of therapeutics.

Appendicitis.—Dr. John B. Deaver, of Philadelphia, read a paper on this subject, stating that the diagnosis is easily established by a localized point of tenderness on palpation. Excruciating tenderness indicated pus, and a sudden fall of temperature often indicated perforation. Early operation made the prognosis better. If the general peritoneal cavity had been invaded, the prognosis was bad. With perforation into the bowel recovery was the rule; into the bladder, the prognosis was very bad. Operation was the treatment for all cases as soon as the diagnosis could be made. We had no way of foretelling whether perforation, gangrene, or pus would ensue, or that it would be a simple catarrhal inflammation. As to the danger, one hundred operations without a single fatality required no comment. Early operation was more of a conservative treatment than a radical procedure. One attack was sure to be followed by another. Early operation was comparatively easy; but, pus once formed, the operation demanded the best of judgment and skill. The median incision should be avoided, as it was necessarily a large one, and the peritoneal cavity could not be so well protected from infection. The abscess should be drained before removing. Unless the appendix was removed the operation was not a curative one. McBurney's operation was the best for chronic cases and prevented hernia.

Dr. Gaston, of Atlanta, while admitting early diagnosis and operation to be imperative, thought it was not always easy to determine that you had a case of appendicitis. He had seen a case where all the usual symptoms were absent, but pus was abundantly present.

Dr. McGonigal, of California, said his experience was recovery in all early operations, but death where the operation was delayed for four or five days.

Dr. Quimby, of New Jersey, thought medicine and nature should be first given an opportunity, and that it was a serious mistake to treat every case as a surgical one. In small places where expert surgeons were not available, what was to be done? He treated this disease as he would peritonitis.

Dr. Wyman, of Michigan, said his experience was limited to cases where suppuration had already taken place, the delayed diagnosis being due to the powerful contraction of the abdominal muscles. As to the cause of the disease, he believed there was a geographical distribution of it, as in malaria, and that the presence of a foreign body was merely a coincidence.

Dr. Murphy, of Chicago, said the diagnosis could best be made within twelve hours after the first attack. The variety of the infection governed the symptoms. Where a blistered condition of the peritoneum existed, as though parboiled, the case was a bad one, and far more fatal than the mere presence of pus.

Dr. Marcy, of Boston, indorsed Dr. Murphy's views.

Dr. Hawley, of Vermont, stated that rigidity of the muscles on the right side of the abdomen was evidence enough for operation in every case.

Dr. Willard, of Philadelphia, believed in early diagnosis and lateral incision.

Dr. Ransohoff, of Cincinnati, thought the removal of the appendix

was not necessary in cases of circumscribed abscess to bring about a radical cure. This could be accomplished by drainage.

In closing the discussion, Dr. Deaver claimed that, where the appendix had not been removed, there was a recurrence in fully 50 per cent. of the cases.

American Surgical Association, New York.

Cancer of the Lips, Tongue, Floor of the Mouth, and Pharynx.—Dr. P. S. Conner, of Cincinnati, stated that cancer of the lip is easily eradicated, while the disease is confined to its free border and to limited infiltration of the underlying tissues, by the V-shaped excision. In the majority of cases this condition does not exist at the time of operation, but the glands under the jaw are implicated. Doubtless at times glandular enlargement is due to irritation, and will subside after the removal of the diseased source, but this is exceptional. Sixty or 70 per cent. of failures to effect cure are due to failure to extirpate affected glands. All enlarged glands should therefore be removed. Thorough exploration for any such should be made. This does not add greatly to the gravity of the operation.

Cancer of the tongue is seen in about one-tenth of all cases of cancer. In a great majority glandular enlargement has been present. It affects the glands and the jaw, those along the anterior edge of the sterno-mastoid muscle and those over the carotid sheath, one set or all, according to the situation, age, and other circumstances of the disease. The final result of operations has been far from satisfactory. Ten per cent. in recent years have died promptly from the operation. Whitehead's death-rate is only 4.5 per cent. The percentage of secondary growths has been from 75 to 95 per cent. When the tongue has been entirely removed recurrence rarely takes place in the stump, but occurs in affected glands. Free and early excision, therefore, is very necessary for a cure. It is far better that now and then a syphilitic or tuberculous tongue should be unnecessarily operated on than that cancer should be allowed to extend its area.

The best method of operating is that which permits the readiest and most complete removal of the disease with the least risk of life. Each case must be operated upon according to circumstances. When the disease has existed but a short time and is located on the free border of the tongue, ablation should be made by the knife or scissors. Hæmorrhage is slight and healing is rapid, the value of the organ being but little impaired. When the disease is so extensive as to require the removal of the whole tongue, Whitehead's operation is a good one. Any operation through the mouth, unless very early and limited, must be supplemented by exploratory incision of the submaxillary region and removal of discovered glands, as even the intervening ducts may be involved. In order to insure better results, more thorough explorations are necessary than are at present practiced. It is through the neck, the floor of the mouth, that we must reach the tongue.

Primary cancer of the pharynx is rare. Operation for secondary growths is, for the most part, useless, if not injurious; primary growths

confined to the velum can be readily removed by knife or scissors. If done thoroughly and early, recurrence may not take place. Cancer of the tonsil penetrates the deep tissues so rapidly as to render operations almost wholly useless. Fortunately it is a rare disease.

Dr. Theodore A. McGraw, of Detroit, Mich., said that he had determined, in future operations on the tongue and mouth, to dissect for exploration all the neighboring lymphatic regions in relation with the seat of the disease in every case,—to go down into the carotid region and explore it thoroughly.

Dr. Christian Fenger, of Chicago, Ill., exhibited instruments for use in tracheotomy and for plugging the pharynx in operations about the nose and mouth, and described an operation which he performed for cancer of the tongue, by which that organ is removed through the floor of the mouth, demonstrating it by drawings.

Dr. Barnes described dissections of the cheek which he made in exploring for affected lymphatic glands in operating for cancer of the lip. Among eighty cases treated by him, two had died from the operation. Of the number whose subsequent histories he had learned, there had been no recurrence in 27 per cent.

Association of American Physicians, Baltimore.

Renal Affections following Influenza.—Dr. C. Baumgarten, of St. Louis, related eight cases which had demonstrated to him that influenza was often the source of degenerative changes in the kidney, changes which do not sometimes become apparent until the influenza has been forgotten. This fact is evidenced by the statistics of life-insurance companies. During the influenza period and following it he had observed albuminuria in 3½ per cent. of the cases examined, while in the period in which influenza did not prevail he had observed but 1 per cent. Besides transient albuminuria, acute degeneration of the kidney, acute inflammation, both forms of chronic diffuse nephritis, and persistent albuminuria not belonging to one of these groups have been observed.

Dr. A. Jacobi, of New York, also testified to the frequency of renal complications in the disease, ascribing them to toxins, as after diphtheria and during typhoid fever. Contrary to what is observed in scarlet fever, these cases usually get well in a few weeks or months, few of them becoming chronic. He advised the use of the centrifuge to facilitate the diagnosis.

Dr. James Tyson, of Philadelphia, had observed several cases of albuminuria in patients free from renal trouble before influenza, and had noted also that so-called healthy, physiological, or cyclical albuminuria became more serious after an attack of influenza, and that casts appeared in the urine.

Dr. F. C. Shattuck of Boston, had seen a number of cases last winter, and related one in which hæmorrhages occurred, with suppression of urine, and later an enormous amount of albumin. Anæmia supervened, followed by neuritis and death.

Selections from Reports of Members of the Annual's Staff of Correspondents.

China.

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Noma.—During the past year I have had twenty-four cases of noma under my care, in patients from 6 months to 8 years of age, all the children of poverty-stricken people living in the highly-malarial city of Peking. Such cases usually prove fatal. The left cheek was the favorite site of the gangrenous spots, but in several cases the disease first appeared in the gums in the median line, destroying them and the alveolar process rapidly. One case commenced in the lower gums and soon destroyed the entire right side of the lower maxilla, which I removed. The wound then healed up, but the child grew progressively weaker in spite of tonics, stimulants, etc., and died of exhaustion about three weeks after the operation. All the cases presented markedly enlarged spleens and profound anæmia. Various preparations of arsenic, iron, iodine, and cinchona were tried, with apparent improvement for a few days, but all the patients ultimately died. Post-mortem examinations are impossible here, so that nothing can be learned of the pathological appearances of the organs of the body. My belief is that the disease is due to malarial infection and that a change of residence and nutritious diet might lead to improvement.

Fistula in Ano.—Of 100 cases of fistula in ano operated on by me or my colleague, Dr. Taylor, 29 were tuberculous and the rest non-tuberculous. Of the 29 tuberculous cases only 2 had more than one external opening. One only seemed to be made worse by operation. This man had slight apical dullness and some cough on admission. The one small sinus was cut and speedy recovery took place, but in three weeks he returned to hospital with abscesses in both lungs and died two weeks afterward. The other 28 cases were all improved in every way by the operation. I have declined to operate on 6 cases with advanced phthisis because they had a dozen or more sinuses and because their lungs were so far involved that death was only a matter of a few weeks. I believe that fistula in tuberculous subjects is just as amenable to operation as in non-tuberculous patients, providing the phthisis is not too far advanced and there is not too much necrosed cellular tissue in the buttocks, making hæmorrhage a source of danger by adding to the general debility. In the case of a man now entirely well who entered hospital some months since, anæmic, exhausted, and unable to stand, I made 63 incisions in a period of three months. He is now robust and doing coolie labor. Iron, quinine, and nux vomica are necessary remedies in nearly all our fistula cases.

Denmark.

DR. F. LEVISON,
REFERENT FOR DEN DANSK LITTERATUR VEDRÖRENDE: ALMINDELIG MEDICINSK PATHOLOGI OG THERAPI, DERI INDBEFATTET, NERVE- OG SINDSSYGDOMME, PÆDIATRIK, OBSTETRIK, GYNÆKOLOGI, HYGIEINE, DEMOGRAPHI, RETSMEDICIN, PATHOLOGISK, ANATOMI, BAKTERIOLOGI.

Alle medicinske Böger, Disputatser, Monographier, Tidsskrifter, etc., der adkomme i Danmark bedes sendt til

DR. LEVISON,
Norrevoldgade, 13,
Köbenhavn.

Subcutaneous Emphysema during Parturition.—ULRIK has observed a case of subcutaneous emphysema suddenly appearing during parturition. (*Ugeskrift for Läger*, 1895.) The patient, who was 28 years old, had been in labor for ten hours and one twin was born, after which the pains recommenced, and, on making an effort, suddenly ceased and the face became swollen. The second twin was delivered by the aid of forceps, and the face of the mother was then so swollen that the eyes could hardly be opened; the swelling extended to the upper part of the chest and back, the front and upper portion of the head being normal. Loud crepitation was heard when the swelling was touched, thus proving it to be caused by subcutaneous emphysema. Complete recovery took place in seventeen days.

Effect of Solar Rays on Embryos.—FINSEN has made a series of experiments to test the influence of the different rays of sunlight on embryos, and found that the blue rays particularly induced movements in the embryo of the triton while still contained in the translucent eggs. (*Hospitals-Tidende*, 1895.) During a period of sixteen minutes these embryos made forty-six movements in blue light, eight in green light, and six in red light. By varying the experiments in different ways he found that the blue-violet rays always induced quicker movements in salamanders, frogs, etc., than any other rays of the spectrum.

Empyema.—SCHON (*Ugeskrift for Läger*, 1895) mentions the case of a child, suffering from empyema after pneumonia, whose finger-tips were swollen in the manner described as "drumstick fingers." The child subsequently recovered from the empyema and the fingers returned to their normal size and appearance.

Diphtheria.—FIBIGER, in bacteriological studies on diphtheria, based on two hundred and twenty cases of angina, as well as catarrhal and scarlatinous forms of a diphtheritic nature, found, in the throats of some perfectly healthy nurses in diphtheria wards, diphtheritic bacilli in full virulence, but in small numbers.

BLOCH (*Ugeskrift for Läger*, 1895) recommends, in the treatment of diphtheria, a 10-per-cent. solution of citric acid, to be given in spoonful doses every two hours.

Arthritis in Pneumonia.—VOGELIUS has observed two cases of suppurative arthritis developed in the course of genuine pneumonia. (*Hospitals-Tidende*, 1895.) In one the sterno-clavicular articulation was affected, in the other the hip-joint; in both pneumococci were found in the pus.

Italia.

PROF. F. MASSEI,
REDATTORE CORRISPONDENTE PER LE LARINGOLOGIA E RINOLOGIA.

Si prega di mandare tutti i giornali, libri, stampe, etc., sulle suggetti sopra nominate che vedono la luce in Italia al

PROF. F. MASSEI,
4, Piazza Municipio,
Napoli.

Clinical Forms of Acute Tonsillitis.—PROFESSOR MASSEI discusses this subject in two clinical lectures, and attempts a pathogenic classification, after the classical one already made by Boulloche and Norris Wolfenden. Red angina may be differentiated clinically from the white form, but the true nature of the disease can only be ascertained by a bacteriological examination. The *red* form is to be divided into :—

I. Erythematous, or superficial.

II. Parenchymatous, or phlegmonous, the causes of which are (1) monomicrobic: (*a*) acute form (Klebs-Lœffler bacillus), (*b*) subacute form (coli bacillus), and (*c*) chronic form (leptothrix,—benign mycosis); (2) polymicrobic: (*a*) acute form (Klebs-Lœffler bacillus and staphylococcus,—mild diphtheria), and (*b*) the same, with pneumococcus or streptococcus,—severe diphtheria.

III. Mycotic angina: chronic form, oïdium albicans; aphthous eruption (staphylococcus and streptococcus); staphylococcus; pneumococcus; streptococcus, associated or not with other bacilli.

The *white* form is to be divided into :—

I. Angina from cocci: (1) monomicrobic: acute forms—(*a*) staphylococcus, (*b*) streptococcus, and (*c*) pneumococcus; (2) polymicrobic: acute forms—due to above micro organisms.

II. Angina from bacilli.

Red angina may be divided, as to localization, into superficial or erythematous, parenchymatous phlegmon, peritonsillar phlegmon, and the white form into lacunar and diffuse.

The indications for treatment given by the author are as follow: ice, cocaine, and sublimate in red, phlegmonous tonsillitis; antitoxin in diphtheria; sublimate in white, non-diphtheritic angina.

Regression, or Spontaneous Recovery, of Pharyngeal and Naso-pharyngeal Tumors.—DR. A. D'AGUANNO, in the *Bollettino della Mâl. del' Orrechio*, etc., October, 1894, relates two interesting cases, the first a boy 3 years old, who had such a large growth in the naso-pharynx that tracheotomy was recommended in order to prevent death by suffocation. The parents objected to the operation, and, although the symptoms increased in severity, the child afterward improved, and after a lapse of three years perfectly recovered, every trace of the tumor having disappeared. The second case was that of a child, 13 years old, who, from microscopical examination, was found to have a telangiectasic fibrosarcoma of the naso-pharynx. After a severe hæmorrhage the growth diminished in size and the child's health improved, but two years later it was again as large as before. [While disagreeing with the author as to the possibility of spontaneous recovery, these cases evidently show that malignant tumors may undergo a temporary diminution in size, with corresponding improvement in health.]

Serum Therapy in Diphtheria.—PROF. F. MASSEI, assisted by DR. A. DAMIENO and PROF. ARENA, has made a series of experiments with this treatment, at first using Behring's serum and subsequently that prepared by Prof. de Giaxa, of Naples. Bacteriological examination in forty cases showed the presence in great numbers of the Lœffler bacillus, associated in nearly all instances with other cocci (staphylococcus, streptococcus, pneumococcus), twice only occurring in a pure form. The presence of the Lœffler bacillus was confirmed in many cases of so-called primary croup, thus elucidating a most important and controverted subject in pathology. Half of the cases showed localization in the larynx, often in a primary form, which so closely resembled stridulous laryngitis that it was only after bacteriological examination that the diagnosis could be confirmed. Two cases were complicated early in the disease with measles, without any membrane in the throat. Only one case of pharyngeal diphtheria proved fatal,—that of an old man of 65 years. There were five deaths from croup, but two of these were in the preagonic stage. Five times only did the croupous symptoms disappear after injection of the serum, and these cases came under observation early. With these exceptions the authors were always obliged to perform intubation (fifteen times in twenty cases, or 75 per cent.), the successful results confirming what has already been pointed out, that in croup intubation is preferable to tracheotomy. It also demonstrates the value of the combined serum and intubation treatment. Before the introduction of antitoxin the presence of false membrane was the principal obstacle to success in intubation. The beneficial effect of the general treatment on the local products in these cases was undeniable, the membranes becoming detached and easily expelled, and it was necessary to retain the tubes in place for a shorter time than usual. In Italy, and especially in Naples, intubation combined with antitoxin has become very popular. In a few cases of malignant pharyngeal diphtheria the value of the antitoxin was demonstrated in a striking manner. Among the forty cases the treatment in some was instituted at a late period, when the clinical form was exceedingly severe; notwithstanding, recovery took place. Only in one case, in which a small quantity of serum was injected on the fifth day, did post-diphtheritic paralysis (of the velum, arms, and legs) occur; however, complete recovery afterward took place. A certain degree of mortality in diphtheria does not lessen the value of the antidiphtheritic serum: (1) because there are cases in which the treatment is begun very late, when the kidneys, heart, or nervous system may be impaired, against which it cannot be successful; (2) when there are complications, such as scarlet fever, measles, etc., in which we cannot ascertain whether some lesions (particularly glomerular nephritis) are to be attributed to one or the other infection; (3) death occurs frequently from suffocation unless intubation or tracheotomy can be promptly performed. But, if time will permit, the antitoxic treatment will succeed.

The microscopical analyses, made in nearly all the cases by Professor Arena, clearly show that antitoxic treatment improves the glomerular nephritis if pre-existent and produced by diphtheria, but never produces it

if not already present. Only a few times was there noticed a transitory eruption of the skin in the form of erythema or urticaria.

Professor Massei and his colleagues have found the serum prepared by Professor de Giaxa to be very successful in practice. One cubic centimetre is said to contain two hundred immunization units,—*i.e.*, a serum two hundred times stronger than the so-called normal serum. In 16 cases treated with this serum by Professors Massei, Damieno, and other practitioners (9 were cases of croup), 14 recovered. The 2 deaths were due to laryngeal localization. Intubation was necessary in 4 of the cases, with 2 recoveries.

Poland.

DR. J. DRZEWIECKI,

Redaktor Korespondent z działu polskiej literatury tyczącej się: Medycyny ogólnej i lecznictwa; pediatryi; akuszerzyi; ginekologii; laryngologii; otologii; hygieny; demografii; medycyny sądowej; histologii; patologii; bakteryjologii; anatomii; fizjologii.

Wszystkie pisma lekarskie, dzieła, rosprawy, monografije, itd., w języku polskim wydane, a tyczące się przedmiotów powyższych, winny być nadsyłane pod adresem

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Królestwo Polskie.

The Relation between Diphtheria and Angina Follicularis.—Opinions differ as to the relationship of these two diseases; according to some, angina follicularis is an independent disease, while others maintain that it is only a mild form of diphtheria. DR. W. FRANKOWSKI (*Medycyna*, February 23, 1895), from observations in his private and hospital practice, is an adherent to the first opinion. He observed more than 3000 cases of acute inflammation of the throat in eighteen years, and at the hospital, during the same period, 7935 cases of diphtheria and 7110 of angina follicularis. His conclusions are: 1. That a gradual disappearance of peritonsillitis abscedens and angina catarrhalis, with gradual augmentation of the number of cases of epidemic follicular angina, serves as an undoubted sign of approaching epidemic diphtheria, while the appearance of the first two forms indicate the disappearance of epidemic diphtheria. 2. That patients affected with follicular angina do not catch diphtheria, and those affected with diphtheria do not catch follicular angina. 3. In patients with follicular angina all preventive inoculations are superfluous, as the angina itself seems to have the property of preventing diphtheria. 4. Follicular angina is more infectious than diphtheria. 5. Patients do not die from follicular angina, while the mortality from diphtheria is greater or less, according to the character of the epidemic and other conditions. The author gives the following table of mortality from diphtheria, which is interesting in connection with the treatment by antidiphtheritic serum, as showing the fluctuation in the number of deaths in previous years:—

Year.	Mortality Percentage.	Year.	Mortality Percentage.
1878,	41.02	1886,	14 06
1881,	31.05	1887,	7.7
1882,	27.08	1893,	14.06
1884,	23.05	1894,	12.08

The Role of Dentition in the Etiology of Diseases in Children.—ARNSTEIN, at a meeting of the Warsaw Medical Society, described two cases in which convulsions could only have been produced by dentition. From his own experience, as well as from that of others, he considers that reflex convulsions from dentition are possible, but rare. Out of 82 cases observed by him, in only 6 could the connection with dentition be found; in the remaining cases the causes were, in 27, the beginning of acute infectious disease; in 12, diseases of the brain; in 29, diseases of the stomach and intestines; in 6, trauma or burns; in 2 the cause was not explained.

But, although he seldom observed convulsions from dentition he very often noticed abnormally increased sensibility of the central nervous system, expressed by general irritability, uneasiness, peevishness, crying, etc. Among other diseases in connection with dentition the author mentions affections of the gums and buccal cavity, and also an aphthous affection; in the latter, however, dentition was not the *causa efficiens*, but only prepared the ground for the entrance of parasites. He quotes Monti as having proved by statistics that aphthæ are seldom observed in children under 6 months nor after the third year, but most frequently during the first and second year, when the greatest cutting of teeth takes place. He believes that dentition is a physiological phenomenon not causing any morbid symptom, but that in many cases pathological symptoms appear, of a reflex character, involving the central nervous system and buccal cavity. It is doubtful whether diseases of the lungs and abdominal cavity as well as inflammation of the membranes of the brain are ever occasioned by dentition.

The Effect of Onions on Diuresis and Perspiration in Healthy Persons.—STAWSKI has studied this subject in the clinic of Professor Pasternacki, by experimenting on eight healthy persons from 22 to 38 years of age. (*Inaugural Dissertation*, St. Petersburg, 1895.) Each experiment lasted six days, and for three days previous the person was under control. The amount administered was from 60 to 100 grammes ($1\frac{3}{4}$ to $3\frac{1}{4}$ ounces). Raw onions, to the amount of 100 grammes ($3\frac{1}{4}$ ounces), taken with mixed diet, did not show any distinct diuretic properties, and did not affect perspiration. The weight of the body in five out of the eight cases increased during the experiments as well as afterward. The quantity of excrements increased, this increase continuing even after the experiments in six out of the eight cases. Raw onions augment the appetite, produce vigor, and afterward cause temporary inclination to somnolence. They also cause thirst and eructation, increase peristalsis, soften excrement, and favor its easy evacuation.

Round Ulcer of the Stomach.—*Sulphate of atropine*, 0.06 gramme (1 grain); *distilled water*, 8 grammes (2 fluidrachms); 2 drops three times a day. Given in two grave cases of long standing, with cessation of all symptoms within fourteen days. (VOINOVITCH, *Gaz. Clin. Botkina*, No. 9, 1895.)

Clinical Notes.

Tuberculosis of the Œsophagus.—In a lengthy and important article ZENKER describes one case of primary and two of secondary ulceration of the œsophagus. (*Deut. Arch. f. klin. Med.*, March 13, 1895.) The first case was that of a tuberculous patient who, for several months before death, suffered from marked dysphagia, which examination with a sound showed to be due to a stricture of the œsophagus at the level of the cricoid cartilage. Post-mortem examination proved this stricture to be of tuberculous nature, the circular ulceration measuring one centimetre behind and four centimetres in front. Here the circumference of the œsophagus was but two and one-half centimetres instead of four and five and one-half as above or below the point of ulceration. The base of the latter was reddish brown; yellow nodules were scattered through it, and it involved only the muscular layer. The edges were irregular and formed by infiltrated and thickened mucous membrane. The microscope revealed a proliferation of the epithelium in the vicinity of the ulceration. Not only did the epithelial layer appear to be thickened, but the cells penetrated the interior of the mucous membrane, as in the atypical proliferations often observed in lupus of the skin. The epithelium stopped distinctly at the point of ulceration, where it was replaced by granulation tissue rich in cells, and also forming the base of the ulceration. The entire mucous and submucous layers throughout the affected parts were infiltrated with granulations, between which were more or less typical tubercles composed of lymphoid and epithelioid cells, with or without giant-cells. Both tubercles and granulations contained numerous tubercle bacilli. The tuberculous process was limited to the mucous and submucous layers, and tubercles were present between the mucous glands and the epithelium on the edges of the ulceration. The muscular layer was in some places infiltrated by small cells, but presented no trace of tuberculosis.

In the second case tuberculosis of the œsophagus was discovered only at the autopsy of the patient, who died of tuberculosis. There was a slight stricture at the bifurcation of the trachea, and a projection or thickening at this point as large as a two-mark piece (half-dollar). The centre of this was a yellowish superficial ulceration formed by caseous infiltration, and involving the mucous, submucous, and muscular layers and the adjacent connective tissue. The diseased portion of the œsophagus adhering closely to the bronchial ganglia had also undergone caseous degeneration. Microscopical examination showed the typical picture of tuberculosis, the bacilli being everywhere present in the specific lesions.

The third case, also in a consumptive, was similar to the second, there being a typical tuberculosis of the submucous and muscular layers of the œsophagus, either in the form of caseous granulations or in the form of flattened tubercles with giant-cells. The subepithelial tissue was slightly infiltrated. There were but few tubercle bacilli, but streptococci were present in large numbers.

The author, who has been able to find but five authentic cases of primary tuberculosis of the œsophagus in literature, attributes its rarity, even in phthisical patients, to the resistance of the epithelium and to the comparatively short sojourn in the œsophagus of matters containing the bacilli. Should the epithelium become damaged in any manner tuberculosis may occur, as in the cases of Breus and Kundrat, in which two tuberculous patients swallowed sulphuric acid with suicidal intent; in Eppinger's case, in which the œsophagus was covered with thrush; and in Zenker's case, in which tuberculosis developed upon a cancerous stricture. In his own case the seat of the ulceration was at the narrowest point of the œsophagus,—between the trachea and the vertebral column. Injuries to the protecting epithelium by the passage of foreign bodies or any other cause might have afforded entrance to the bacilli. The superficial character of the lesions showed that the infection had begun on the surface and gradually invaded the deeper parts.

Fracture of the Patella.—Dr. George Ryerson Fowler, of Brooklyn, discusses this subject in the June number of the *Annals of Surgery*, and describes a new method of treatment which consists essentially in exposing the fragments as an intermediate procedure,—*i.e.*, after the immediate effects of the injury have subsided and before the occurrence of ligamentous union,—for the purpose of clearing their surfaces of intervening soft parts and the application of fixation-hooks somewhat resembling Malgaigne's, except that a single instead of a double pair is employed. The parts are kept at rest for from fourteen to twenty-one days, or sufficiently long to permit of the subsidence of the effects of the traumatism upon the surrounding structures, as well as the closure of a possible rupture of the upper recess of the capsule of the joint as described by Riedel. During this period of waiting the time is advantageously occupied by daily cleansings of the parts with soap and water and the application of gauze compresses wetted with the boro-salicylic solution of Thiersch, secured in position with a figure-of-eight bandage. The latter also serves to promote coaptation of the fragments.

The operation wound by which access is gained to the fracture is placed either transversely or vertically; if the former is employed it commences at the inner edge of the patella slightly above its middle, curves sufficiently downward to include beneath the flap the line of fracture, crosses the front of the lower fragment just above the attachment of the ligamentum patellæ, and ascends to terminate at a point opposite to the place of commencement. The half-moon-shaped flap thus marked out is dissected back just far enough to expose the line of fracture and no farther. Careful and systematic removal from between the fragments of the intervening mass consisting of stretched and torn shreds of fibrous tissue and partially organized blood-clot is now practiced. This is greatly facilitated by first incising along the free margin of each fractured surface and loosening the mass at these points first. The blade is now slipped between the mass and the fractured surfaces, and the former freed from the latter without difficulty and removed as one piece. Care is taken, during this portion of the

operation, not to tilt or otherwise disturb the fragments, and to expose the joint surfaces as little as possible. No irrigating fluid should be employed; whatever portions of the *débris*, blood-clot, etc., which may chance to fall into the gap between the fragments, and cannot be picked out by the dressing-forceps, may be removed with bits of sterilized gauze grasped between the blades of hæmostatic forceps.

The fragments are now made to approximate each other as much as possible. One of the fixation-hooks is thrust into the bone at the site of the attachment of the ligamentum patellæ to the lower fragment. The other is pushed through the skin and into the bone at the site of the attachment of the rectus femoris to its upper border. With the fractured surfaces in perfect coaptation, as seen with the flap still turned back, the shanks of the fixation-hooks are drawn together and secured, and the fragments held in a most secure manner. Two or three very fine silk sutures may be employed to secure the edges of the soft parts along the line of fracture. The flap is now replaced and sutured with a continuous subcuticular silk suture. Sterile gauze dressings and non-absorbent cotton, secured in position by rollers, are applied; a plaster-of-Paris splint insures immobilization. If the cover of the transverse incision is properly managed the lower hook will be so placed as to secure the bone directly in the line of the incision, thus avoiding the passage of the former through a wound of its own in the skin. If the vertical incision be employed, both upper and lower hooks can be secured in the bone in the line of the incision. The transverse incision (U-shaped) gives better access to the parts if well curved. The fixation-hooks are permitted to remain for about three weeks. Should it become necessary for any reason to remove them earlier, this can be done by opening the splint at the anterior knee portion. The patient may recline, or sit, or go about in a wheel-chair during the convalescence.

The advantages claimed for the method by Dr. Fowler over the primary operation are the improved condition of the parts, their minimal exposure, the short space of time required for the operation, and the lessened risk as regards sepsis and the anæsthetic.

Creasote in Large Doses in Tuberculosis.—Dr. John R. Conway, of New York, has tried this drug in almost all forms of tuberculosis, including the peritoneal, joint, bone, glandular, and laryngeal varieties, treating, in all, about four hundred cases, with uniformly good results. (*New York Medical Journal*, June 1, 1895.) He has had no difficulty in administering 20-minim (1.3 grammes) doses to patients who had previously suffered from intense gastric irritation, with vomiting and indigestion. The method of administration and the quality of the drug are of great importance. The author now invariably gives it in capsules mixed with codliver-oil in the proportion of one to two, a capsule containing 4 minims (0.26 gramme) being most serviceable, given immediately after eating and never on an empty stomach. He insures the quality of the drug by having the capsules made by a reliable firm, his results being thus rendered uniform. If there be any gastric irritation before beginning its use, he quiets the stomach by giving bromide of sodium, 15 grains (1 gramme); subnitrate of bismuth, 10 grains (0.65

gramme); and pepsin crystals, 3 grains (0.2 gramme), every four hours for twenty-four hours, when 2-minim (0.13 gramme) doses of creasote are given after each meal, increasing the amount gradually when the stomach becomes more settled, usually within four or five days.

In regard to the method of increasing the dose the author gives the following rule: Begin with 2-minim (0.13 gramme) doses three times a day; in acute cases increase the dose by 2 minims (0.13 gramme) every fourth day until 12 minims (0.78 gramme) are given at one time, then observe the results of the largest dose for several weeks, and, if the improvement is not satisfactory, carefully add 2 minims (0.13 gramme) more every eight or nine days until a 20-minim (1.3 grammes) dose has been reached; then persist with this quantity until the symptoms warrant a diminution of the amount. He has frequently used the highest dose for four and five months at a time before decreasing it, with the most satisfactory results. The chronic cases do not, as a rule, require so large a dose or to have it so rapidly increased. In his average chronic cases the patients use 12 minims (0.78 gramme) three times a day, commencing with the small quantity (2 minims—0.13 gramme), increasing by 2 minims (0.13 gramme) every six days to 8 minims (0.52 gramme), then every second week to 12 minims (0.78 gramme), according to the effect.

In every case, in the first week or ten days, there were troublesome eructations of gas flavored with creasote; but in every instance this entirely subsided after the creasote had corrected the fermentation caused by old indigestion, which it invariably does. This action struck him so forcibly that he now uses 2- and 4-minim doses in many cases of dyspepsia and bowel indigestion, with more rapid curative results than he has ever obtained from any other drug.

It is well to impress all patients with the absolute necessity for keeping under the influence of the treatment for at least two years, no matter how well they may seem. Dr. Conway is of the opinion that many will require four years' constant dosage before they can safely cease the use of it, while others, who began treatment earlier, before extensive deposits were formed, can be said to be free from danger after two years. It must also be remembered that the expected specific effects take place very much more rapidly in cases diagnosticated soon after the origin of the disease; this is particularly remarkable in acute pulmonary tuberculosis. He has seen the temperature reduced to normal within three weeks, without any rise occurring afterward, in a patient who had been suffering with this peculiar form for less than a month. She was able to leave her bed in two weeks, and was discharged from the hospital at her own request within a month. After a year of the larger doses the average patient can be kept safe from relapses on about 8 minims (0.52 gramme) after each meal, provided no active symptoms are present at the time, as would be indicated by even one degree of rise of temperature.

Pentosuria.—SALKOWSKY has observed two new cases of what he calls pentosuria, the urine containing sugar, but not being fermented by yeast (*Berlin. klin. Woch.*, April 29, 1895). The sugar belongs to the class con-

taining five atoms of carbon, and its phenylhydrazin derivative crystallizes in yellow needles at 159° C. (318° F.). It is to be distinguished from the same derivative of grape-sugar by its insolubility in cold water. He tests as follows to determine its presence in the urine: To 200 or 500 cubic centimetres (6½ or 16 fluidounces) of urine are added 5 to 12 grammes (1¼ to 3¼ drachms) of phenylhydrazin previously dissolved in acetic acid. The mixture is heated to ebullition, and then kept in a water-bath at the boiling-point for an hour or an hour and a half. It is then allowed to cool. If the urine contain pentose the liquid will be of a brown color, and on cooling a sediment of yellow needles will be formed. If the urine contain neither glucose nor pentose there will be only a brownish powder at the bottom of the vessel. The precipitate is dried, again dissolved by heat, and again crystallized. The melting-point of the crystals is then ascertained, and must be 159° C. (318° F.). Tollen's test may also be used, phloroglucin being dissolved to saturation, in 5 or 6 cubic centimetres (1¼ or 1½ fluidrachms) of fuming hydrochloric acid. With this solution 1 cubic centimetre (15½ minims) of urine is treated, and heated in a water-bath. If the urine contain pentose a red coloration is observed, which gradually reaches the bottom of the tube. With Fehling's solution the urine presents a green and then a yellowish color, but reduction does not take place. Fermentation and polarimetric tests give negative results.

Clinically the affection does not appear to be idiopathic in nature. In one of the cases glycosuria existed, but in nine cases of diabetes examination did not reveal the presence of pentose. The origin of pentose in the urine has not been ascertained, but, owing to its rarity, an alimentary origin is regarded as improbable. Hammarsten has recently ascertained the presence in the pancreas of a nucleo-proteid yielding pentose by separation, resembling, and probably identical with, that found in the urine. It seems possible that pentosuria may be due to an excessive formation of this nucleo-proteid, but it is also possible that pentose exists normally in the healthy organism, being destroyed by oxidation. Pentosuria would, therefore, imply a deficient organic oxidation,—a theory which appears to be the most plausible.

Westermark's Operation for Uterine Prolapse.—Dr. Otto Holst calls attention in the *Lancet* (June 15, 1895) to this operation, which he has used with perfect and permanent success in twenty-two cases which had proved rebellious to other methods. The plan is described as follows: The patient being under the influence of an anæsthetic and in the lithotomy position, any hypertrophy or ulceration of the cervical lips is cut away, first the anterior and then the posterior. The bleeding is stopped with deep sutures, which are left long for subsequent use. The wounds in the lateral fornices, caused by the excision, remain open for the time being. Should a cystocele be present an elliptical piece of the vaginal wall (not only the mucous membrane), extending from the anterior lip of the portio vaginalis to within one centimetre from the urethral opening, is dissected up, and the wound closed by deep and superficial sutures. If now, by means of the long sutures left in the cervix, the prolapsed uterus be drawn to the right side,

the left lateral attachment of the vagina to the paracervical and paravaginal connective tissue becomes well marked. An incision is then made along the anterior fold thus made apparent, beginning from the anterior end of the wound left open in the cervix, and extending straight down the side of the vagina to within about three centimetres of the vaginal opening; parallel with this, and from one to one and a half centimetres behind, another incision is made from the posterior end of the cervical wound. These incisions meet below at an acute angle. The intervening piece of the vaginal wall is dissected up so that the subjacent connective tissue lies exposed. The bleeding is stopped and deep sutures are inserted, but not tied. The uterus is now drawn over to the left side and the same performance repeated; the womb is then pushed up and the sutures on either side are tied. If the perineum be imperfect, a perineorrhaphy, according to the principles laid down by Tait, is performed. The novelty in this method of treatment lies in the operation of colporrhaphy being *lateral*. Dr Westermark's reason for this modification of operating is that it is the strong connective tissue in the broad ligaments which keeps the vagina *in situ* even when the perineum is imperfect, and not the connective tissue found between it and the bladder, anteriorly, and the rectum posteriorly. That this view is correct is shown by the fact that prolapse of the anterior and posterior vaginal walls occurs without corresponding prolapse of the bladder or rectum, as the case may be. This is, no doubt, due to the loose and lax condition of the connective tissue found in these situations. He compares the relation between the uterus and the vagina to a funnel hanging down the neck of a bottle, and contends that, the uterine ligaments—*i.e.*, the upper part of the broad ligaments, the round ligaments, and the sacro-uterine ligaments—being too feeble to keep the uterus in position, it is the lower part of the broad ligaments and their strong connective tissue which keep it *in situ*.

Dystocia due to Hysteropexy.—Prof. A. Goubaroff reports from the clinic of Dorpat (*Sem. Méd.*, June 5, 1895) a case of difficult labor due to an anterior hysteropexy which caused such strong adhesions as to render Cæsarian section necessary. The case confirms the assertion of Greig Smith, that, where a serous surface is brought in contact with the wound itself, the adhesions formed are particularly solid and resistant. The patient had undergone the operation of ventrofixation some four years previously. Becoming pregnant, all went well until the moment of delivery, when a shoulder presentation was diagnosed, with the back of the child anteriorly. All attempts at version were impossible on account of the elevated and anteverted position of the uterus. The neck remained closed, and the condition of the patient became so dangerous that laparotomy was resorted to. This showed adhesions of a finger's breadth along the entire cicatrix of the wall. These were separated and the uterus placed in its normal position; but, in spite of this, dilatation did not occur, and a stricture of the vagina was found to exist, whether due to the fixation of the uterus is not stated. Cæsarian section then became necessary, both mother and child living. The author advises against passing any sutures through the fundus of the uterus, placing the stitches below, and not above, the point of insertion of the round ligaments.

Chloralose as an Hypnotic.—MARANDON DE MONTYEL, from a study of fifty-eight cases in which he employed this drug as an hypnotic, condemns its use in insanity, general paralysis, and senile dementia, and warmly recommends it in epilepsy. (*Revue de Méd.*, May, 1895.) Féré reported excellent results a year ago from its use in this class of cases, and the observations of the present author confirm his assertions. It is to be noted, however, that patients who sleep well and whose attacks of mania are notably shortened under its influence, seem at the same time to be very susceptible to its physiological action; this is especially true of epileptics, who show extreme sensibility both to its favorable and unfavorable effects.

Recent Suggestions in Therapeutics.

Bismuth in Ulcerative Gastric Affections.—Wash out the stomach in the usual way with a solution of *bicarbonate of soda*, and introduce through a stomach-tube 2½ to 3 drachms (10 to 12 grammes) of *bismuth subnitrate* in 15 ounces (465 cubic centimetres) of *water*, shaking this mixture continually to prevent its settling. Let it remain ten minutes in the stomach, meanwhile removing the tube. Then carefully withdraw the *water*, which should come away clear, leaving the *bismuth* deposited on the inflamed and ulcerated membrane of the stomach. Most efficacious in chronic ulcerative gastritis from alcoholism and in simple round ulcer of chlorotic girls. (FOURRIER, *La Presse Méd.*, April 10, 1895.)

Cardiac Disease in Pregnancy.—For anæmia and want of cardic tone give *liquor arsenicalis*, 5 minims (0.32 cubic centimetre), and *liquor ferri dialysati*, 10 minims (0.65 cubic centimetre), or *liquor strychniæ*, 5 minims (0.32 cubic centimetre), three times daily. Use *digitals* if there be marked œdema or effusion with dyspnœa. Forbid exertion immediately after taking food, also straining at stool. If necessary give a gentle laxative of *confection of senna* or *sulphur lozenges* at bed-time. If there is sleeplessness, give moderate doses of *bromide of potash* or *sulphonal.*

During labor let the patient assume the sitting posture, and give subcutaneous injections of *ether* or rectal injections of *brandy* during the first stage, according to the condition. If the liquor amnii be excessive, rupture of the membranes before complete dilatation of cervix will give instant, but not permanent, relief. As soon as dilatation is complete, in ordinary cases, effect artificial delivery, not allowing the patient to endure any bearing-down pains. Give an anæsthetic, preferably *ether*, and apply the forceps. Extract the fœtus slowly, placing a twelve-pound sand-bag over the fundus uteri during the process to counteract the rapidly descending abdominal pressure, and thus avoid the consequent collapse from cerebral anæmia or right-heart insufficiency.

Cardiac Disease in Pregnancy (*continued*).

After labor give *strychnia* to stimulate the heart's action. Leeches over the præcordia also give relief in distressing symptoms. (JOHN PHILLIPS, *Practitioner*, June, 1895.)

Glycerophosphates.—Indications: Breaking down or depreciation of the nervous system, as in convalescence from acute diseases, especially influenza, in phosphaturia and the neurasthenia following it, ataxic pains, tic douloureux, sciatica, chronic lumbago, and Addison's disease. Favorite formulæ of author: *Glycerophosphate of lime*, 6 grammes (1½ drachms); *glycerophosphates of sodium*, *potassium*, and *magnesium*, each 2 grammes (31 grains); *glycerophosphate of iron*, 1 gramme (15½ grains); *tincture of St. Ignatius's bean*, 30 drops; *pepsin*, 3 grammes (46 grains); *maltin*, 1 gramme (15½ grains); *tincture of kola*, 10 grammes (2½ fluidrachms); *cherry-syrup*, 200 grammes (6½ fluid-ounces). A tablespoonful during midday and evening meal. Or the following cachet, given at meal-time: *Glycerophosphate of lime*, 0.30 gramme (4½ grains); *glycerophosphates of sodium*, *potassium*, and *magnesium*, each 0.10 gramme (1¾ grains); *glycerophosphate of iron*, 0.05 gramme (⅞ grain); *powder of St. Ignatius's bean*, 0.03 gramme (½ grain); *pepsin*, 0.15 gramme (2¼ grains); *maltin*, 0.05 gramme (⅞ grain). For the treatment of chlorosis and anæmia: *Glycerophosphate of iron*, 0.05 to 0.10 gramme (⅞ to 1¾ grains); *rhubarb powder*, 0.05 gramme (⅞ grain); *extract of quinquina*, 0.15 gramme (2¼ grains). To make one pill. Two or three to be given daily at meal-time. (ALBERT ROBIN, *Bull. Gén. de Thér.*, May 30, 1895.)

Neurasthenia.—Tonic: *Grenache wine*, 840 grammes (27 ounces); *syrup of orange-peel*, 100 grammes (3¼ ounces); *tincture of coca*, 30 grammes (1 fluidounce); *tincture of quinquina*, 20 grammes (5 fluidrachms); *tincture of calumba*, 10 grammes (2½ fluidrachms); *tincture of nux vomica*, 1 gramme (15½ minims). A wineglassful before noon and evening meal. For headache: *Antipyrin*, 0.50 gramme (7¾ grains); *valerianate of quinine*, 0.10 gramme (1¾ grains). For one cachet, to be taken morning and evening. Or, 10 to 15 drops of Ewald's mixture: *Hydrochlorate of morphine*, 0.20 gramme (3 grains); *hydrochlorate of cocaine*, 0.25 gramme (4 grains); *tincture of belladonna*, 5 grammes (1¼ fluidrachms); *bitter almond-water*, 25 grammes (6½ fluidrachms). For gastric pains, with flatulence and intestinal dyspepsia, the following, recommended by M. Albert Robin: *Tincture of rhubarb*, *tincture of badiane*, *tincture of menispermum cocculus*, each 3 grammes (46 minims); *tincture of ipecac*, 1 gramme (15½ minims); *tincture of opium*, 1 gramme (15½ minims). Six drops in a little water before meals. (*Menispermum cocculus* contains, as its active principle, *picrotoxin*, and, if not obtainable, *Menispermum palmatum*, or *calumba*, might be substituted.) For constipation: *Euonymin*, 1 gramme (15½ grains); *podophyllin*, 0.30 gramme (4½ grains); *extract of belladonna*, 0.30 gramme (4½ grains). For 30 pills. One at each meal. (EMILE LAURENT, *Traitement de la Neurasthénie*. Paris: Maloine.)

Parotitis.—Isolate the patient and let him rest in bed, taking light nourishment,—milk, soup, and eggs. Apply the following over the swollen parts: *Hyoscyamus-oil*, *chamomile-oil*, each 30 grammes (1 fluidounce); *Sydenham's laudanum*, 5 grammes (1¼ fluidrachms). Cover with a layer of cotton. Keep the bowels regular and give three teaspoonfuls daily of the following potion: *Sodium salicylate*, 5 grammes (1¼ drachms); *sodium benzoate*, 10 grammes (2½ drachms); *julep of orange-flowers*, 30 grammes (1 fluidounce); *linden-water*, 120 grammes (4 fluidounces). Rinse the mouth with the following antiseptic solution: *Thymol*, 0.25 gramme (4 grains); *carbolic acid*, 1 gramme (15½ grains); *tincture of eucalyptus*, 10 grammes (2½ fluidrachms); *water*, 1000 grammes (1 quart). Also use it for irrigation of the ear. (A. Malbec, *Tribune Médicale*, June 5, 1895.)

Scrotal Pruritus.—*Carbolic acid*, 20 parts; *neutral glycerin*, 75 parts; *alcohol*, 25 parts; *distilled water*, 300 parts. Make a mixture of 1 part of this solution and 4 parts of very hot water; dip eight or ten layers of tarlatan in it and apply as a compress, completely enveloping the scrotum, keeping it in place by a rubber suspensory. Give, as a sedative, *carbolic acid*, 0.05 gramme (⅞ grain); *extract of valerian*, 0.10 gramme (1¾ grains); *powder of valerian*, 0.20 gramme (3 grains). To make one pill. From 0.20 to 0.60 gramme (3 to 9¼ grains) to be given daily at meal-time. Prohibit all stimulants, and in severe cases order exclusive milk diet. (Brocq, *La Presse Méd.*, June 1, 1895.)

Typhoid Fever in Children.—Diet: In the second year, milk, bouillon, light soups, barley-water sweetened with honey, wine lemonade. Let the patient drink regularly and abundantly to facilitate diuresis and elimination of toxins. For nursing infants, give the breast but half as frequently, substituting boiled water or sweetened barley-water. Medical treatment: The first day, *quinine hydrochlorate*, 1 to 1.50 grammes (15½ to 24 grains), in divided doses of 0.50 gramme (7¾ grains), beginning at 5 or 6 P.M. This induces sleep, lowers the temperature, and causes the patient to come out of his stupor. Next morning, if improvement is manifest, continue the *quinine* every evening if the temperature exceed 39° C. (102.2° F.) at 4 P.M. Give *benzo-naphthol* or *betol*, 0.20 gramme (3 grains) twice daily, an injection of *cold water* (boiled) once daily, and 10 to 15 grammes (2½ to 3¾ fluidrachms) of *citrate of magnesia* every two days. If the stools are fetid, omit the latter drug for a day and substitute *calomel*. If on the second day no improvement is to be noted after the *quinine*, exclude all medicines and give cold baths, rigorously following the Brand method. For very young and nursing children, give the first bath at 22° C. (72° F.), cooling to 20° C. (68° F.); the second at 20° C. (68° F.), cooling to 18° C. (64° F.). Continue it only five minutes, and remove the child as soon as there is the least evidence of chill. If respiration should fail (as sometimes occurs with cold baths) remove the child at once, rub the body vigorously, and employ traction of the tongue according to Laborde's method, when respiration will readily be restored. Use cold

Typhoid Fever in Children (*continued*).

affusions on the head during the bath. On removal envelop the child in a blanket and give a hot drink. Take the rectal temperature before and after the bath, and, if it is above 39° C. (102.2° F.), every two hours give another bath as soon as it exceeds that figure. Carefully cleanse the mouth and nostrils, and use *carbolized steresol* to dress any erosions of the skin that may appear. (MARFAN, *Tribune Médicale*, April, 1895.)

Urticaria.—Apply the following pomade: ℞ *Acid. carbolic.*, 15 grains (1 gramme); *ess. menth. pip.*, 15 minims (1 cubic centimetre); *zinci oxidi*, 3 drachms (12 grammes); *lanolin.*, ½ ounce (16 grammes); *vaselin.*, ad 2 ounces (62 grammes). Ft. ung. The application of the ointment can be preceded by antipruriginous lotions of chloral or eau-de-cologne. Give internally two to ten of the following pills per day: ℞ *Quiniæ hydrochlor.*, 1½ grains (0.1 gramme); *ergotine*, 1½ grains (0.1 gramme); *extract belladonna*, ⅛ grain (0.01 gramme). M. ft. pil. j. (BROCQ, *Practitioner*, June, 1895.)

Monographs Received.

The editor acknowledges, with thanks, the receipt of the following monographs:—

Risultati ottenuti mediante la cura collo siero del Behring in alcuni casi di crup e di difterite, dal **Luigi Mazzetti** e dal **Luigi Bacchi**, Bologna, 1895.——Notes on an Hitherto-Undescribed Skin Disease, by **Otto Lerch**, New Orleans, La., 1895.——On Whooping-Cough, by **William W. Johnston**, Washington, D. C., 1895.——La Diphthérie au Pavillon d'Isolement de l'hôpital Lariboisière et son traitement par le sérum de Roux, par **A. Gouguenheim**, Paris, 1895.——Aseptic Prophylaxis of Asiatic Cholera; Arsenization, by **Reginald Barkley Leach**, Paris, Texas.——Hay Fever, by **L. F. Page**, Indianapolis, Ind.——Intestinal Anastomosis, by **Jacob E. Johns**, Denver, Pa., 1895.——Tubercular Tumors of the Larynx, by **J. Payson Clark**, Boston, Mass., 1895.——Du Catarrhe Naso-Pharyngien, par **E. J. Moure**, Bordeaux, 1895.——Teratoma of the Naso-Pharynx, by **Walter J. Freeman**, Philadelphia, 1895.——Insomnia in Children, by **A. G. Wollenmann**, Ferdinand, Ind.——Early Diagnosis of Carcinoma of the Stomach, with the Bacteriology of the Stomach, by **Fenton B. Turck**, Chicago, 1895.——Three Cases of Laminectomy, by **Claude A. Dundore**, Philadelphia, 1894.——Dislocation and Double Fracture of the Upper Third of the Humerus, by **B. Merrill Ricketts**, Cincinnati, O., 1894.——Camphor-menthol; A Supplementary Report, by **Seth Scott Bishop**, Chicago, Ill., 1895.——An Aural Masseur, by **Chevalier Jackson**, Pittsburgh, Pa., 1895.——Method of Holding Children for Throat and Nose Treatment, by **Walter J. Freeman**, Philadelphia, 1895.——Treatment of Opium Poisoning by Permanganate of Potassium, by **William Moor**, New York, 1895.——Grip and its Effects on the Nose, Throat, and Ear, by **Seth Scott Bishop**, Chicago, Ill., 1895.——Typhoid Ulcer; Cerebral Cyst, by **B. Merrill Ricketts**, Cincinnati, O., 1895.

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(End of Editorial Department of Journal for July, 1895.)

The Treatment of Uric-Acid Gravel.

Under the head of uric acid gravel is placed that diseased condition in which uric acid is precipitated in the urine either in the tubules of the kidney, urinary tract, or in the urine immediately after being passed. In an interesting article on the chemical pathology, symptoms, and diagnosis of this condition, Dr. Vaughn Harley makes, among others, the following practical remarks with reference to the treatment: "The treatment of uric-acid gravel takes two directions, according as we desire to increase the solubility or decrease the amount of uric acid formed.

"It is well to remember that in the majority of cases uric-acid deposits are due to an increased tendency to precipitation, and not to excessive formation of uric acid. In cases due to an increased tendency to precipitation we have to give drugs which hold uric acid in solution. I have found piperazine of great service, particularly in all cases in which gravel has been due to diminished solvents and not excessive formation of uric acid.

"In fact, it appears to have no action whatsoever on the quantity of uric acid daily formed in the organism, but merely on its solubility. On this account I always give it in such cases in combination with alkalies, either in the shape of alkaline waters or potash bicarbonate combined with iodides. The diet in such cases is not of much importance except in favor of salines and vegetables. In cases where the uric-acid deposits are due to excessive formation, a carbohydrate is the most useful. Starch, sugar, and vegetables should, therefore, be the staple diet, and meat and fish only in small amounts. Alcohol should be prohibited, as it causes an increase in the quantity of uric acid voided. Quinine and arsenic are most valuable in cases where gravel is due to an excessive formation of uric acid. While moderate muscular exercise is of service, excessive exercise is harmful. Although alkalies are of some assistance, they, like piperazine, are only of secondary importance by increasing the solubility of the uric acid formed."

"Melachol."

R. M. Kerley, M.D , Superintendent of Health Department of Female Hospital, St. Louis, Mo., writes that he has kept accurate notes and made practical observation in a number of cases and believes "Melachol" is scarcely less than magical in its effects upon all ill nature. He says it certainly holds the cholesterin in a liquid form and prevents the formation of gall-stones and the clogging of the gall-duct, nor does it produce a less happy effect upon the secretions of any gland in the body. Even the mucous glands respond to its action and old and doubly chronic cases of uterine diseases, accompanied by acrid and offensive discharges, rapidly improve under its benign stimulation, and irregular and painful menstruation, if not through organic displacement, is wonderfully improved by its administration just prior and during the period of menstruation.

He has had excellent results in its use in disorders of the liver and kidneys. It has never failed to respond in increasing the secretions of these organs and greatly assisting nature where aggravated disturbances have existed for years.

His most noticeable result was its action in a case of chronic hysteria in a woman, aged 35, of careless habits.

Examination showed that an hypertrophied condition of the uterus existed, together with congestion of the ovaries, with continuous pain, to subdue which morphia had been used aud the habit contracted. He discontinued all other remedies except morphia, and gave Melachol in drachm doses three times a day and full laxative dose (tablespoon) twice a week, continued for a month. At this condition, and by reducing the dose of morphia without the patient's knowledge until none was taken, she was surprised to know it, but found she could do without it altogether, and, as the cause had been removed, she did not resume the habit nor did she crave the drug.

He has fully satisfied himself of its efficacy and medicinal qualities, and recommends it, without reserve, to the profession.

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FRANCE.

SOCIÉTÉ NATIONALE DE MÉDECINE, LYONS.

Abortion in Bifid Uterus.—GOULLIOUD was called to curette a woman of 20 years who had aborted a short time previously and whom the physician in charge supposed to be incompletely delivered, as she still suffered from pain and hæmorrhage. Abortion had been followed by digital delivery of the ovum, and several intra-uterine injections were given afterward on account of the fetid character of the lochia, though there was no fever. Eight days after abortion pain developed first in the right, then in the left, side of the abdomen, accompanied by a swelling which was at first supposed to be a tubal dilatation; later, however, it in no way resembled such a condition, but a movable tumor with its largest axis vertical. Examination by the vagina showed a small septum in the neck, and further investigation showed that the right half of the neck was soft and permeable as far as the internal orifice, as from a recent delivery, while the left half was hard and showed the characteristics of the nulliparous cervix. The idea of a double uterus naturally suggested to the author a double pregnancy, with abortion on the right side and threatening abortion on the left. In the hope of preventing the latter, laudanum injections were prescribed, but several hours later a fœtus of three and one-half months was expelled entire. The following day the condition of the cervix was modified, and it was difficult to distinguish the intra-cervical septum, thus showing that a bifid condition of the uterus may pass unnoticed, even in a number of labors.

SOCIÉTÉ DE CHIRURGIE.

Choledochotomy.—M. QUÉNU, in a communication on this subject, stated that an exploratory operation was indicated when biliary retention persisted for three months without amelioration. Such an operation is not always easy; when there are adhesions the relations are changed and the vesicle is not readily found. By following the course of the umbilical vein the ductus choledochus will be found in a plane oblique to it. If its relations are normal the liver can be elevated and the left index finger introduced into the foramen of Winslow, which is drawn down, while the right index finger follows the left border of the gastro-hepatic omentum. When a calculus is present he prefers to have recourse to choledochotomy, when simple pressure of the finger is not enough to cause the stone to pass into the duodenum. The higher up the calculus,—that is, the nearer the liver,—the more difficult is exploration, incision of the canal, and suture. In such cases the duct may be left open, as the fistula will heal spontaneously, but drainage must be established in order to isolate the area from the rest of the abdominal cavity. The author recommended operating at a single sitting if protecting adhesions are present; if not, tampons may be used to provoke adhesions and a second operation performed eight days later, incising the canal and removing the calculus.

M. MICHAUX performed eight laparotomies on patients apparently affected with biliary lithiasis. Only four of them, however, presented calculus, and the ductus choledochus was only involved in two of the cases. Exact diagnosis is almost impossible, and exploratory laparotomy is indicated when medical and thermal treatment has been tried without avail for a period of three months. The portion of the duct above the duodenum is the most easily reached, and is therefore the true surgical region. If the calculus is in the retroduodenal region and cannot be pushed up, duodenotomy should be practiced, as done successfully by Pozzi. Choledochotomy is rarely a primary operation, but is usually complementary, and exploration of the duct is thus facilitated. The difficulties of operation are considerable, as the region contains numerous vessels and injury to large veins is to be feared; these vessels hide the canal, which is difficult to see, and still, in order to make a proper incision, both duct and calculus must be under one's fingers. If the duct is somewhat dilated and the stone low down the surgeon is obliged to operate somewhat in the dark. M. Michaux is not a partisan of the operation in two stages, and, contrary to Quénu, he advises lateral incision upon the external border of the right muscle, since the intervention must frequently include the vesicle; if the incision is not sufficient, a second transverse one must be made. He has always sutured the canal in his cases, some bile exuding, but ceasing at the end of several days.

M. TUFFIER described a new method of performing choledochotomy by a lumbar incision. This is made, as for nephrectomy, parallel to the twelfth rib. The kidney is pushed upward, the second portion of the duodenum being then to the outside and the ductus communis choledochus to the inside, together with the posterior surface of the pancreas. Internally to

the duct is the portal vein, and lying against the spine the vena cava. The duodenum is drawn upward and outward, and the finger hooks the choledochus above the head of the pancreas, exploring and opening it if necessary. The operation seems less dangerous to the author because extraperitoneal, and if a fistula occur it is outside of the peritoneum; besides, drainage is more easily established.

M. Poirier did not view the operation with favor, owing to the danger of wounding large veins. He recommended the anterior method, guided by the foramen of Winslow.

Reboul presented the case of a woman in whom acute hydronephrosis complicated by subhepatic inflammation had been diagnosed. He made a lumbar incision parallel to the twelfth rib and encountered a tumor, which, when incised, gave exit to 500 grammes (1 pint) of muco-pus and six biliary calculi. The case was one of calculous cholecystitis, the right kidney, movable, being situated behind and below the vesicle. The lips of the latter were attached to the wound, and on account of the serious condition of the patient nephropexy was not performed. The after-course was without complication. In this case the lumbar incision had proved superior to the anterior one.

Académie de Médecine, Paris.

Alcoholism in France.—A communication by Laborde served as the starting-point of a discussion on the prophylaxis of alcoholism. Rochard painted a vivid picture of the progress of the vice in France and its disastrous results, and proposed the re-establishment of the law of 1865. Lagneau and Lancereaux dwelt upon the relation of alcoholism to tuberculosis, and from the discussion it was evident that the members regarded it as a fact beyond doubt that the increase of the vice in question was in direct relation with the increase of consumption, particularly in men. Of 10,681 deaths from the disease registered in Paris in 1893 6553 were men and 4128 women. As a prophylactic measure increased taxation of wine-shops was generally advocated, with restriction of the number of drinking-places, which in Paris alone is 34,500.

Herpes and Diphtheria.—Cadet de Gassicourt and A. Robin reported cases confirming the opinion expressed by Dieulafoy, that herpes and diphtheria may often be confounded, and that bacteriological examination alone will enable a positive diagnosis to be made. As most physicians are not prepared to make such bacteriological examinations, the authors urge the establishment of laboratories for the purpose.

Excretion of Urea in Cancer.—The assertions of Rommelaere, of Brussels, that hypoazoturia and hypophosphaturia was a constant condition in cancerous patients, and therefore of value in the diagnosis, led Duplay, Cazin, and Savoire to a series of investigations in fifteen cases of cancer of various organs, leading them to results entirely contrary to those of Rommelaere. They found that the amount of urea diminished only when the patients could no longer take sufficient nourishment; hypoazoturia cannot therefore be considered as a symptom of cancer, but simply one of

the manifestations that may lead to cancerous cachexia when the patients can no longer take food. If a change of regimen assuring sufficient nourishment can be given it will cause an elimination of urea not greatly differing from that of normal subjects. The same is true of phosphaturia, which is not as constant in the disease as has been claimed.

GREAT BRITAIN.

British Orthopædic Society, Liverpool.

Intractable Talipes Equino-Varus.—Robert Jones, in opening a discussion on this subject, maintained that the condition was always an avoidable one, and that the relapses so often alluded to were generally due to carelessness on the part of the patients and friends and sometimes on the part of the practitioner. The relapses frequently occurred because the surgeon did not recognize their causes; these were (*a*) insufficient correction of deformity, (*b*) superincumbent body-weight on outer side of tarsus, (*c*) slack and lengthened state of muscles opposed to the deformity. Frequently surgeons were content to merely twist the foot until they were able to get it comfortably into the straight position, and yet as soon as the little patient put his limb to the ground one could see that the flexor muscles of the foot had not recovered their power, and the result was that the whole body-weight fell on the outer side of the tarsus. The foot is not cured until the patient can voluntarily place it in the position of valgus, and he should not be allowed to walk until the foot is so far recovered that each step he takes tends to improve its position; in other words, until the act of walking becomes a beneficial factor in the correction of the deformity. It was impossible to lay too much stress upon the influence, in the maintenance of deformity or upon its recurrence, of the overstretched muscles on the convex side of the deformity. In proof of this Mr. Jones instanced his treatment in infantile paralysis where contractions had existed for some years, and their influence upon the lengthened opponent muscles. In discussing the methods of treatment, including that of manual correction, subcutaneous division of deep structures and tendons, forcible wrenching, tarsoclasis, open incision, linear osteotomy, removal of astragalus or cuboid, tarsectomy and Pirogoff's operation, he insisted upon the fact that the goal might be reached very successfully by different routes. Some surgeons, like Wolff, of Berlin, were able to show extremely satisfactory results where the hand alone was used, and this in extremely intractable cases. Phelps had described uncommonly good results by means of his open incision, and Mr. Jones had personally seen some very useful feet after Lund's excision of the astragalus. After describing Phelps's operation Mr. Jones argued that it had more effect on the varus deformity than on the equinus, and the cases he had seen after the operation seemed rather deficient in the power of putting the heel to the ground. Phelps's argument for open incision seemed founded on the ground that it was indiscreet to work in the dark, but at the same time it was noticeable that he had very considerably modi-

fied the length of his incision, so that it became almost essential, by reason of the small incision now made, to introduce out of sight the tenotome for the division of some of the deep structures. Mr. Jones had performed Lund's operation on six cases and wedge-shaped tarsectomy thirteen times; but although his results were fairly satisfactory he had discarded the operative treatment for that of forcible wrenching. He then described in detail the mode of twisting by means of Thomas's wrench. He always divided the tendo Achillis before proceeding to further treatment, as its contraction often had to do with the varus deformity as well as that of the equinus. He rarely found it necessary to divide any other tendons. Occasionally several wrenchings were preferable to forcing the foot into position at once. After each wrenching the foot became quite capable of being molded into any position. In the after-treatment he preferred the application of a cheap iron shoe to the plaster appliances now commonly in use, and he described the simple device of adding an iron "flapper" on the outer edge of the boot in order to complete the eversion of the foot during walking. The rotation inward of the leg he corrected last of all by osteoclasm. This internal rotation could always be avoided if one began treatment early by twisting in their long axes the tibia and fibula outward, grasping the lower end with the right hand and the upper end with the left. There was very little pain attached to the method; treatment had only to be continued for a few months, and there was absolutely no risk involved. This could not be said of the cutting operations, with the inevitable percentage of mortality.

Mr. Tubby thought that in the normal state the action of the extensor and flexor muscles was not alternate and distinct, but that the muscles acted in concert; there was a wide field for observers for investigating the conditions of the equilibrium of muscles; he never found tarsectomy necessary, but had seen some very bad results from it; cases were sent out too early and relapses occurred not seen by the surgeon; he considered the wrench a very satisfactory instrument in intractable cases, the ligaments in youth being elastic, but he was opposed to Phelps's operation. Excessive division of vessels favors gangrene of the foot.

Mr. Murray said that, in the treatment of congenital talipes equinovarus, all were agreed that the equinus part of the deformity should be dealt with by division of the tendo Achillis, but all were not agreed as to the treatment of the varus. He stated his objections to Phelps's operation, and also to wrenching. The wrenching was painful and had to be often repeated,—an important matter with poor patients from a distance. Of the several operations practiced, he personally preferred the removal of a wedge-shaped piece from the outer side of the foot, irrespective of bones or joints, and was well satisfied with the results he had obtained. He had performed the operation forty-two times in thirty-four patients. The dangers from the operation were practically *nil*, and much time and expense were saved, as the patients walked well without instrumental support in less than three months.

Mr. Luke Freer was of opinion that the very few cases of intractable club-foot with which surgeons engaged in orthopædic practice had to deal

were a reflection on the patients' friends, or, more often, on the practitioner. Severe relapsed cases, treated by tenotomy and daily manipulative after-treatment, would usually be well, with pliable feet, under three months, and he showed several photographs of cases so treated. He was in favor of the wrench rather than tarsectomy in cases where the hand was not sufficient; he agreed with the use of simple retentive apparatus, easily removable, for manipulation. Of all the cases of tarsectomy he had seen he could not call any one really satisfactory.

MR. NEWBOLT said that osteoclasis should be done through the tibia and fibula, not through the femur.

MR. ROBERT JONES, in reply, referred to the length of time in treatment, which was slight after the first wrenching. No relapse occurred if the child was not allowed to walk before the weight was borne on the inner side of the tarsus instead of the outer. The chief advantage of this method was safety. Private patients would invariably prefer a non-cutting operation. There would be very few intractable cases of club-foot if medical men would learn how to deal with them sufficiently early.—*Medical Press and Circular*, July 3, 1895.

LONDON OPHTHALMOLOGICAL SOCIETY.

Myopia in Relation to Nasal and Pharyngeal Disease.—DR. RAYNER BATTEN read a paper on the association of certain forms of myopia with disease of the nose and larynx, describing a special form of myopic fundus which he associated with certain diseases of the nose and pharynx. The chief characteristics of this form of myopia were (1) the existence of localized posterior staphylomata at or in the immediate neighborhood of the optic disc or on the nasal side of the fundus; (2) the tilting of the optic disc in the direction of the staphyloma; and (3) the œdematous condition of the more prominent margin of the optic disc. This œdema, or "pseudoneuritis," he considered as secondary to, and caused by, the tilting of the disc. The conditions of the nose and throat with which he associated this form of fundus were adenoid vegetations, enlarged tonsils, deviation of the septum, blows on the nose and forehead, ozæna, syphilitic disease of the nasal bones, and chronic otorrhœa. He quoted cases in which myopia had immediately followed the onset of some of these conditions, and, in conclusion, said that the presence of the œdema was generally a sign that the cause was still in active operation; that the visual acuity was seldom good in these cases, even when the degree of myopia was low, and was especially bad when the staphyloma was on the nasal side of the optic disc; that the whole condition was one indicative of a progressive myopia, and that the œdema and tilting both tended to disappear with the progress of the myopia.

DR. E. A. BROWNE considered that the evidence adduced was insufficient to convince those who had not given it special attention. Many constitutional causes required to be eliminated, such as scarlet fever or rheumatic fever, as well as other exhausting diseases, before myopia could be reasonably attributed to a local lesion.

MR. SPENCER WATSON was disappointed that Dr. Batten had not put forward a theory to explain the relationship between nasal disease and myopia. He was disposed himself to regard both conditions as dependent upon some common constitutional cause. He quoted instances where interstitial keratitis had been followed by myopia in constitutional syphilis, indicating, he thought, that there was softening of the whole eye.

DR. BATTEN, in reply, said that the connection between the sphenoidal cells and fissures and the blood-supply to the eye was very close. The eyeball should be regarded as an end-organ, and interference with its blood-supply was likely to lead to changes analogous to those produced in clubbed fingers.—*Lancet*, July 13, 1895.

ITALY.

SOCIETA LANCISIANA, ROME.

Necrosis of Pancreas.—MARCHIAFAVA reported the case of a man, 45 years old, who died in collapse, after peritoneal symptoms lasting three days. At the post-mortem examination a vast hæmorrhagic area was found in the transverse mesocolon and in the great omentum, which was rich in fat; but the principal lesion was situated in the posterior cavity of the omentum, at the level of which was a large cretaceous mass surrounding the pancreas and penetrating into its fibrous structure. Microscopical examination showed that this mass consisted of a fatty granular substance containing a large number of crystals; the necrosed portions, which involved the connective tissue as well as the glandular parenchyma, showed cavities covered with the same crystals and containing fluid fat. From this and analogous cases published by Balzer, Chiari, Bastianelli and others, it seems to the author that this peripancreatic and pancreatic necrosis may constitute a separate disease, with its own special pathological anatomy and symptomatology.

Balsams in Ocular Disease.—G. NORSA has used balsam of Peru and balsam of Tolu, in the form of 1- to 3-per cent. ointments, in ciliary blepharitis, superficial keratitis, opacities of the cornea, phlyctenular keratoconjunctivitis, superficial corneal ulcerations, deep ulcers with iritis, hypopyon, and other affections. He finds that the remedies are well borne, have an antiphlogistic and antiseptic action, and that they serve as excellent cicatrizants, especially for the cornea.

UNITED STATES.

SOCIETY OF THE ALUMNI OF BELLEVUE HOSPITAL.

Electrolysis in Fibrous Ankylosis.—DR. F. W. GWYER, of New York, reported upon some cases of fibrous ankylosis treated by electrolysis. He employs the continuous current, moderately large electrodes, and a solution of ammonium chloride. The current is passed directly through the joint,

with the negative pole nearest the adhesions. The application lasts from ten to thirty minutes and is repeated every two to five days. The amount given depends on the susceptibility of the patient to pain, the condition and amount of reaction of the skin, and the size of the electrodes. It will range from 40 to 150 milliampères.

He finds that the best results from the method are obtained in cases of injury; the shorter the interval between this injury and the beginning of the galvanic treatment, the more rapid and greater the improvement, which is more manifest and rapid at the beginning of treatment than later on. All his cases of injury showed great and immediate improvement. In cases due to disease the results were slower, and in two out of five cases the method entirely failed. The improvement was marked in the direction of increased motion, lessened pain, reduced swelling, more normal circulation, and increased general usefulness of the limb.

Dr. George Woolsey had not applied the electricity personally, but had sent his patients to Dr. Gwyer or had had them treated by the house staff of the hospital. The cases could be classed as (1) cases of injury, (2) cases of disease, and (3) cases of stiffness following operation. In all these benefit had resulted from the treatment, and in some cases it had been surprisingly rapid as well as marked. He recalled one or two cases of tubercular joint disease successfully treated in this way. Two cases had been cured by injections of iodoform emulsion, and the application of electricity had greatly relieved the pain and increased the motion of the joints without the pain attending passive motion. The larger number of cases in which good results had been obtained were those following injury. With one exception, these cases had done extremely well. This method of treatment, of course, came in competition with massage, passive motion, and even breaking up of adhesions under ether. The last he had usually found rather unsatisfactory, because the adhesions generally reformed after a time. Of course, massage and passive motion were valuable, but they were often not well applied. He felt that his own experience now was sufficiently large to justify him in recommending this treatment very highly, in conjunction with other methods, or where other methods had failed.

Dr. Reginald H. Sayre said that he had had but a limited experience with the method. He had sent some old tubercular cases to Dr. Gwyer in the hope that the motion of these stiff joints might be improved. He did not feel that the effect in this class of cases had been great, although in a case of rheumatism he had seen it act very beneficially in relieving the pain and stiffness. From a theoretical stand-point he felt that the method of treatment should be beneficial, but why it should be more successful in rheumatic conditions than in stiffness of joints following tuberculosis he could not say. Galvanism should act upon the human tissues and produce electrolysis just as it did in the laboratory, and therefore one would expect that it would dissolve the adhesions.

Dr. C. G. Sproull referred to the effect of galvanism in treating a synovitis of the knee-joint occurring in his own person. The synovitis had been the result of injury, and had occurred about seven weeks ago. The knee

had been treated by elevation, massage, and the Martin bandage, which had been removed twice daily and massage treatment given, and afterward by plaster of Paris. At the end of one month the plaster had been removed, and on using the knee for about a week the synovitis had been nearly as bad as before. Seven days ago Dr. Gwyer had begun treating him with galvanism. At this time the circumference over the patella had been seventeen inches on the affected side, as against fifteen inches and three-quarters over the other patella. He had received four applications, with the result that there had been a marked diminution in the fluid and œdema, and a very great increase in the motion.

Dr. Gouley said that two or three professors of electrical science had lately said that they were surprised that physicians were using some of the forms of electricity for the cure of certain diseases, for they could not conceive that ordinary electricity or galvanism could possibly have any effect except as a kind of gymnastics of the muscles, and that nothing short of electrolysis had any positive action. Electrolysis exerted a destructive action, as its name implied, and it was supposed by Dr. Gwyer to exert some mysterious selective effect on certain adhesions within a joint. This curious selective effect he could not understand. He would like to know whether there was any explanation of such a phenomenon as the selection and dissolving of these adhesions. He believed that he had been one of the first to use the electrolytic process in this country. He had employed it in a tumor of the thigh which had proved to be a sort of hygroma. In this case the electrolytic process had been so thorough that a large abscess had formed. This had been the experience of other surgeons. The electrolytic process had been applied in cases of stricture of the urethra with the almost invariable result of causing a traumatic stricture. He had had under his observation several cases that had been reported as cured by electrolysis, and yet he had found, a few months after the treatment, that they had bad traumatic strictures. In conclusion, he would ask whether the electrolytic process had any selective effect on these deep-seated processes.

Dr. L. W. Hotchkiss thought that the paper showed quite clearly that galvanism had no selective effect on old, well-organized adhesions, and that the author had found, as many others had done, that the best results had been obtained in the more recent cases. During the past few years he had had an opportunity of using electricity at the Roosevelt Dispensary. He had employed a weak galvanic current, although in a somewhat desultory and routine manner, and in connection with massage, active and passive motion in various painful joints, and in recent ankylosis. In almost all cases of Colles's fracture, with stiff and painful joints, in which electricity had been used, the result had been satisfactory, but, inasmuch as douching and rubbing and motion of the joints had been used with the electricity, it was difficult to say in these cases how much the electric current had really accomplished.

Dr. Gwyer said, in reply to Dr. Gouley's question, that on the removal of the positive electrode, after the employment of a heavy current, one would find evidence of a charring action of the current, whereas the skin

under the negative electrode would show rather a vesicant action. He did not know that any physician or electrician could say positively what was the action of the current on the tissues beneath the skin. He believed, however, that the electrolytic action of the current was exerted most powerfully on newly-formed fibrous tissue, and, by regulating the amount of current, its action could be quite closely confined to this tissue.

Dr. Gouley said that his question yet remained unanswered, and he did not believe it could be answered. He would challenge all those who practiced electrolysis to go farther. In point of fact, there was no selective affinity,—at least, it would be very strange if there were. If electrolysis were employed consistently it would result in the destruction of all the tissues in the locality treated. The reports of the cases of fractures, with more or less adhesions about the wrist-joint, had particularly interested him; but he had never seen a case of Colles's fracture in which, after a reasonable time, there had not been good motion. The tendency had been to extend the splints beyond the joints and keep them in that position for several weeks, and, of course, as a consequence there would be temporary stiffness. With the short splints there need never be any stiffness. If there should be any stiffness, the interrupted electrical current to whip up the muscles would undoubtedly be useful, and electrolysis would be unnecessary, or, perhaps, harmful.

Dr. J. F. Erdmann said that he saw no reason why, in recent cases, just as good results could not be obtained by massage and passive motion. He had seen a good many cases of stiffness after fractures, and yet he had not found it necessary to resort to galvanism. In one case, in private practice, he had found stiffness after Colles's fracture, but in this patient there had been a rheumatoid arthritis. He had used galvanism in several instances, but had not observed any benefit from it.

Dr. Parker Syms said that for a number of years he had also worked with fracture cases in the Roosevelt Dispensary, and had observed the effect of galvanism. Since leaving the dispensary he had used the other means without the galvanism, and his results in the same class of cases had seemed to him equally good. He had often employed active motion instead of passive motion. The cases reported in the paper seemed to indicate that the greatest improvement had occurred in just those cases where improvement was what was to be expected naturally at the stage at which the treatment was begun. He had used surface irritation about joints by the Paquelin cautery with much satisfaction, and it was possibly the surface irritation produced by the current that had produced the benefit. While at Bellevue Hospital he had devised a splint, made of perforated sheet-lead, to be used in cases of Colles's fracture, with the idea of avoiding undue immobilization of the joint.

Dr. Sproull said that the treatment had acted in his own case as a cautery, and it was probably by the stimulating action of the current on the circulation that the good effect had been produced.

Dr. Gwyer, in closing the discussion, said that he had been much pleased with the criticisms evoked by the paper. His reason for limiting

his paper to histories of cases was that nothing was definitely known about the action of the electric current beneath the skin, and, the subject being so broad, he had preferred presenting his results rather than his theories, and would only say he believed that there was, first, dissolution of the newly-formed fibrous tissue, and, secondly, a stimulating effect (possibly similar to that produced by the thermo-cautery), which increased the flow of blood to the part, and this hastened absorption of the dissolved adhesions. If every case of fracture were properly treated there would probably be no need for electrolysis, or massage, or other after-treatment, but this was not the case.—*New York Medical Journal*, June 8 and 22, 1895.

PENNSYLVANIA STATE MEDICAL SOCIETY.

Fat in Pulmonary Consumption.—Dr. THOMAS J. MAYS, of Philadelphia, in an article on the value of fat as a constituent of the body (*New York Medical Journal*, June 1, 1895), laid special emphasis on the fact that fats and oils did not play the important part which they were popularly supposed to do in nutrition, and also on the fact that proteids were of greater value as fat-producers in pulmonary consumption than they were generally believed to be. Every experienced physician knew that oil and fats produced dyspepsia in many such patients, and did no good in some with whose digestion they seemed to agree, while there were a few who did well under their use, but whose fat did not seem to have any staying qualities. It seemed to him that oily and fatty foods conferred a real benefit only on a minority of consumptive sufferers, and that much greater service was rendered to the nutrition of such patients by the administration of albuminous foods, the important ones among which were: freshly-expressed beef-juice, beef, mutton, lamb, milk, eggs, oysters, clams, liquid peptonoids, beef-powder, meat-juice, beef-peptones, etc.

An important point was the influence of rest and exercise on the fattening process of the human body. Was physical activity more conducive to fat-building than rest, or was it not? This might be said to depend altogether on circumstances. There was no doubt that in health exercise gave both fat and strength, but it was quite different with the invalid. The fat which was stored up in health represented so much surplus capital laid up for a rainy day; but the consumptive had no surplus capital and lived, as it were, from hand to mouth. All his energies were devoted to the maintenance of those bodily functions immediately necessary to life,—such as circulation, respiration, digestion, innervation, etc.,—and very frequently these were carried on imperfectly. To him, therefore, exercise was meaningless, for he had no capital to exercise on until he got stronger and laid up some. Hence he must practice economy. He must restrict his outgo and increase his income. This he could do only by resting. The author had frequently observed that, with no other change in the treatment than the substitution of rest for exercise, consumptives showed a marked and distinctive improvement and gain in flesh.

It was also of great interest in this connection to consider the influence

of the nervous system on nutrition. Whether there were special trophic nerve-fibres or not, it was quite clear from the large number of experiments which had been performed that the nutrition of that part of the body suffered whose supplying nerve was divided or injured. Clinical evidence pointed out the same It was well known that in neuralgia the limb or area of tissue to which the affected nerve was distributed became emaciated and lost its fat.

CLOUSTON has stated ("Mental Diseases," page 469) that thinness was the almost constant accompaniment of melancholia, and that fattening of the patient was its natural cure; also, that this depraved or weakened trophic energy speedily tended to end in phthisis pulmonalis. In fact, he believed that melancholia had a special proneness to terminate in pulmonary consumption. Phthisis and melancholia ran a parallel course in this respect. Could we not discern in this, he asked, a confirmation of the view that a causative relation existed between disease of the nervous system and disorder of nutrition? Was it not probable from this that the building of fat was intimately dependent on the integrity of the nervous system? This probability was strongly confirmed by the therapeutic action of strychnine. It was well known that this agent had no other influence than that which it exerted on the nervous system, and yet Dr. Mays said that he knew of no other single drug under the administration of which consumptives fattened more promptly than under strychnine when it was given in gradually increased doses and combined with suitable rest and nutritious food.

AMERICAN GYNÆCOLOGICAL SOCIETY, BALTIMORE.

Deep Incisions of the Cervix in Labor.—J. CLIFTON EDGAR, of New York, reports three cases in which he employed deep incisions of the cervix to bring about rapid delivery in eclampsia (*American Journal of Obstetrics*, June, 1895). In the first operated on, a year before the report was made, both mother and child were saved, and the patient apparently suffers no inconvenience from operation other than from a partially united bilateral cervical laceration that might have followed normal labor. This woman had eight convulsions before operation and delivery. No eclamptic attacks followed the operation. The second patient was brought to hospital in coma with total suppression of urine and acute parenchymatous nephritis. She was practically moribund from eclampsia when operated on, and died sixteen hours after delivery, never having regained consciousness. Her child was saved. Nine convulsions occurred before the uterus was emptied and a severe eclamptic attack within the half-hour preceding delivery. Two slight convulsions occurred after the uterus was emptied. The third patient entered hospital in a generally water-logged condition, with commencing pulmonary œdema. Two convulsions occurred in the fifty minutes preceding operation, in spite of the use of chloroform. By combined mechanical dilatation and deep incisions the woman and her twins were saved. The operation, in the opinion of Edgar, should only be undertaken when the entire supravaginal portion of the cervix is fully dilated; in

other words, when the defective dilatation is confined to the vaginal portion of the cervix. In either primiparæ or multiparæ examined during the last week or ten days of gestation, changes in the lower uterine segment and the supravaginal portion of the cervix have proceeded so far as often to result in complete obliteration of the latter structure, and thus render the conditions suitable for this operation. When, during pregnancy or labor, the supravaginal portion of the cervix has been drawn up into the body of the uterus, or can be made to disappear by appropriate mechanical means, and grave danger threatens mother or child, complete dilatation can be secured in a few minutes by means of from two to six deep incisions radiating from the os to the utero-vaginal junction, and the uterus emptied in a few minutes by appropriate means. In cases of multiparæ where the supravaginal portion of the cervix is still present, mechanical dilatation is to be preferred to bloody dilatation by means of deep incisions, and is, moreover, generally sufficient. In the presence of immediate danger, however, the supravaginal portion still being present, the two procedures can be combined to advantage, mechanical dilatation being employed until the internal os has been made to disappear and the dilatation completed in an instant by the deep incisions. It is not necessary or advisable to repair the incisions immediately after labor, as spontaneous union usually occurs. Moreover, the suture prolongs the operation and may be a possible source of local irritation to cause further convulsions in cases of eclampsia. In the thirty-five cases reported by Dührssen, the originator of the method, hæmorrhage never occurred where the uterus was well contracted. He has restricted the operation, however, to cases of extreme urgency threatening immediate death to mother and child; and Edgar also expresses the belief that the operation is a serious one and not to be undertaken without thorough familiarity with the mechanism of dilatation and the surgical anatomy of the parturient cervix.

NEW YORK STATE MEDICAL ASSOCIATION; FIFTH DISTRICT BRANCH.

Methylene-blue in Chyluria.—AUSTIN FLINT administered methylene-blue in a case of chyluria due to the filaria sanguinis hominis (*New York Medical Journal*, June 15, 1895). The effects of the drug were decided and prompt. After the administration of 2 grains (0.13 gramme) every four hours during the day, on March 5th, the parasites were very few at 11 P.M.; the only two found were deeply stained with blue and their movements were extremely sluggish, the urine being clear, but intensely blue. On the fourth and the seventh days no parasites were found, although the treatment had been discontinued after the first day. On the eighth day the urine became milky, and on the night of the ninth day the parasites were found in great number, but their movements were not very active. On the tenth day the treatment was resumed and continued for five days. Three days after, the blood being examined at night, a very few motionless filariæ were observed. Since that time, and up to the present writing (more than a year), the urine has been normal, and the patient has been restored to perfect health.

This single experience points to the possibility of benefit from methylene-blue in the treatment of other diseases due to the filaria, such as chylous collections in the peritoneal cavity and in the cavity of the tunica vaginalis testis, hæmaturia, and elephantiasis.

Dr. Flint has also used methylene-blue with success in cases of malarial enlargement of the spleen rebellious to quinine, in doses of 1 to 1½ grains (0.065 to 0.1 gramme) in capsules two or three times daily, about 30 grains (2 grammes) of powdered nutmeg being given with each dose to guard against bladder irritation. Having used this remedy for seven or eight days he discontinues it and substitutes quinine, with excellent results.

Selections from Reports of Members of the Annual's Staff of Correspondents.

Norway.

DR. F. LEVISON,
REFERENT FOR DEN DANSK LITTERATUR VEDRØRENDE: ALMINDELIG MEDICINSK PATHOLOGI OG THERAPI, DERI INDBEFATTET, NERVE- OG SINDSSYGDOMME, PÆDIATRIK, OBSTETRIK, GYNÆKOLOGI, HYGIEINE, DEMOGRAPHI, RETSMEDICIN, PATHOLOGISK, ANATOMI, BAKTERIOLOGI.

Alle medicinske Böger, Disputatser, Monographier, Tidsskrifter, etc., der adkomme i Danmark bedes sendt til

DR. LEVISON,
Norrevoldgade, 13,
Köbenhavn.

Sacral Tumor in the Fœtus.—G. ANDERSSEN describes a case (*Norsk Mag. f. Läg.*, p. 122, 1895) in which a fœtus at term could not be extracted, though the lower extremities had been delivered. Examination showed a tumor attached to the sacral region by a pedicle as thick as the wrist, and rather hard and lumpy, but with some soft parts. The tumor was opened and about 500 cubic centimetres (1 pint) of a greenish, grumous fluid removed. Delivery was then readily effected. The tumor weighed 1500 grammes (3 pounds) after evacuation of its fluid contents, being about the same size as the trunk of the fœtus. It contained a great number of cavities filled with colloid substance and also some cartilage.

Rapid Development of Hepatic Cancer.—BONNEVIE (*Norsk Mag. f. Läg.*, p. 127, 1895) observed a case in which cancer of the liver developed with excessive rapidity. The patient was a previously healthy man, aged 37 years, who, in November, 1893, began to suffer from gastric trouble. In January, 1894, pain appeared in the right hypochondrium, and hypertrophy of the liver became apparent and increased steadily. The patient died in February, 1894, and post-mortem examination showed colossal carcinomatous degeneration of the liver.

Etiology of Serous Pleurisy.—KR. THUE has observed 35 cases of serous pleurisy and 23 cases of empyema during four years,—from 1890 to 1894. Of the former, 32 cases were without lung complications, and yet a large number of these patients showed unmistakable signs of tuberculosis after a relatively short lapse of time. The author therefore concludes that a great percentage of the cases of serous pleurisy is due to tuberculosis, though a few are due to exposure to cold or some similar ordinary cause.

The fluid was examined bacteriologically in 30 cases, the result being negative in 18 and microbes being found in 12. In 1 case the tubercle bacillus was present, in 9 cases various streptococci or staphylococci, and in 2, in which no microbes were found, inoculation of the fluid in a guinea-pig caused tuberculosis. Most of the cases of empyema were consecutive to pneumonia, and examination showed the presence of pneumococci in the exudate.

Russia.

DR. J. DRZEWIECKI,

РЕДАКТОР-КОРРЕСПОНДЕНТ
изъ области русской литературы, касающейся: Общей медицины и терапіи, педіатріи, акушерства, гинекологіи, ларингологіи, отологіи, гигіены, демографіи, судебной медицины, гистологіи, бактеріологіи, анатоміи и физіологіи.

Всѣ періодическія, медицинскія изданія, сочиненія, стат'и, монографіи и т д., изданныя на русскомъ языкѣ и касающіяся вышепоименованныхъ предметовъ должны быть адресованы на имя

ДРА ДРЖЕВЕЦКАГО.
87 Краковское Предмѣст'е,
Варшава.

Muscular Work and Arterio-sclerosis.—N. TH. CHIGAYEFF has made a study of this subject among peasants and factory-hands (*Vratch*, No. 15, 1895), and asserts that the continued physical labor of peasants during harvest-time exercises a distinct influence on the condition of the vessel-walls, causing them to become harder and more irregular in shape, a change taking place in the vessels which may be called false arterio-sclerosis. During the winter, when these people enjoy a period of rest, the vessels return to a more or less normal condition. A distinct change may be noted in the vessel-walls in persons doing hard work in factories; the walls become solid and crooked, the second sound of the aorta becomes more pronounced and the first sound diminished. Even in young subjects degeneration of the vessels occurs, with symptoms of real sclerosis. A marked difference may be noted in the effect of muscular work on the workman in the field and the workman confined in a heavy atmosphere, with small intervals of repose. In the diagnosis of arterio-sclerosis the author believes that the following points should be borne in mind: (1) The possibility of a physiological sclerosis, in the majority of cases in old age; (2) a transitory stage of false arterio-sclerosis in the development of some forms of real sclerosis; (3) pathological changes in the vessel-walls, due to former diseases or to increased blood-pressure, and frequently present even in youth; (4) increased blood-pressure under muscular work, and varying at different hours of the day; (5) height of the blood-pressure; (6) the frequency of pulse and respiration, which is not parallel to the blood-pressure, but depends on individual peculiarities, on the kind of work, and the quality and quantity of food.

Tuberculosis and Genital Infection.—DOBROKLONSKY, from a number of careful experiments (*Vratch*, Nos. 19, 20, 1895), concludes that tubercular infection may be conveyed through the genital apparatus from man to woman and *vice versâ*, but only when there are present in these organs tubercular foci,—a condition rarely met with. This method of infection, therefore, in comparison to others, is but of secondary importance; however, as local tubercular processes in the genital apparatus, either in the male or female, may take such a course as not to cause general infection or

threaten life, and may even be latent, existing without the knowledge of the patient himself, it must be admitted that such persons may be a source of infection during a long period of time, and under certain conditions may spread the disease.

Treatment of Furuncles.—R. ANTONEWICZ, in cases of furuncle (*Voyenno Medical Journal*, January, 1895) from twenty-four to forty-eight hours old, takes a drop of crystallized carbolic acid on the point of a sound, heats it to the melting-point and presses it on the furuncle, rubbing it slightly. Pain ceases on the second day, and no further treatment is required. In cases three or four days old carbolic acid does not abort the disease, but it does change its course, rendering suppuration painless.

Vicarious Menstruation.—OSWIECIMSKI (*Nowiny lekarski*, April, 1895) describes a rare case of vicarious menstruation in a patient who had menstruated from her 18th year and had married at 24, but had had no children. After ten years of married life her husband died of consumption. Three months before his death menstruation failed to appear for the first time, but the right mammary gland became greatly swollen, the nipple rosy, and a large quantity of colostrum could be squeezed out from it. The pain in the gland extended to the arm. These symptoms lasted three days and then gradually disappeared, to return each month instead of the regular menstruation. The left breast remained unchanged. The author observed the condition six times, up to the date of his report.

Sweden.

DR. F. EKLUND,
Brefväxlande Medarbetare för den
SVENSK MEDICINSK LITTERATUR.

Af alla i Sverge utkommande medicinska tidskrifter, bocker, afhandligar, monographier a. s. v. torde ett exemplar benäget öfversändas till

DR. ABRAHAM FREDRIK EKLUND,
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Stockholm.

Blindness in the Northern Countries of Europe.—PROF. T. WIDMARK, in a clinical lecture (*Hygiea*, vol. 57, p. 386, 1895), stated that, according to the census of 1890, there are in Denmark 1190 blind persons, or 5.3 per 1000 of the inhabitants; in Sweden, 3948, or 8.3 per 1000; in Norway, 2565, or 12.8 per 1000; and in Finland, 3702, or 15.5 per 1000. The most common cause of blindness in Finland is trachoma, which is greatly prevalent among the native Fins, who constitute 86.44 per cent. of the population. In the year 1873 the number of blind people among the Fins amounted to 23 per 1000, while among the remaining Scandinavian population it was only 10.6 per 1000. Sweden is almost free from trachoma. In Norway, in 1862, gray cataract caused about 40 per cent. of the blindness, and in 1872 about 50 per cent. Of 118 cataracts from age, operated on by extraction at the Ophthalmic Clinic of the Seraphim Hospital, in the years 1893 and 1894, not less than 21 were overripe. In Sweden violence is oftener the cause of blindness than trachoma and cataract. Among 11,726 patients at the Ophthalmic Clinic of the National Hospital, in the years 1890 to 1894, there were 50 persons blind in both

eyes, 8 having lost their sight in consequence of direct injury to both eyes and 8 from sympathetic ophthalmia. In the Scandinavian blind-schools blennorrhœa neonatorum is the prevalent cause of blindness,—viz., 24.6 per cent. in Stockholm (1879 to 1894), 23 per cent. in Copenhagen (1889), 20.25 per cent. in Christiania (1893 and 1894), 25.76 per cent. in Helsingfors (1894), and 34 per cent. in Kuopio (1893).

Since the application of the Crédé method the number of cases of blennorrhœa neonatorum at the ophthalmic and pædiatric polyclinics of Stockholm have decreased from 99 in 1884, among 8235 patients, or 1.2 per cent., to 29 in 1890, among 12,079 patients, or 0.24 per cent.

In the blind-schools of Stockholm there are, of sympathetic ophthalmia, 10.6 per cent.; atrophy of the optic nerve, 5.88 per cent.; keratitis, 7.9 per cent. In those of Copenhagen, atrophy, 14.99 per cent.; scrofulosis, 14.99 per cent.; congenital cataract, 11.5 per cent. In those of Christiania, scrofulosis, 20.25 per cent.; atrophy, 10.8 per cent.; cataract, 10.8 per cent. In Helsingfors, variola, 10.15 per cent.; cataract, 8.475 per cent. In Kuopio, trachoma, 20 per cent.; variola, 18.1 per cent.

The diminution of blindness in Northern Europe is due to improved medical attention, the general introduction of the method of extracting cataract, vaccination, the eye-speculum, and aseptic procedures. Out of 409 operations for cataract, performed from 1859 to 1877 in the Seraphim Hospital, 58 failed in consequence of suppuration; while, out of 145 extractions in the past two and one-half years, 1 eye only was destroyed from this cause. Even at the present time 30 to 40 per cent. of the cases of blindness are produced by infectious processes.

Syphilis of the Labyrinth.—MAGNUS MÖLLER has observed several cases of this affection (*Hygiea*, vol. 57, No. 4, 1895). The first was a man, 35 years of age, infected with syphilis, who had not previously suffered from any affection of the ears. His disease, having taken the ordinary course, had afterward shown two relapses in the form of erythematous angina, the treatment of which had been energetic. Ten months after the infection and two months after treatment with mercury and potassium there appeared, slowly and gradually, symptoms of some derangement of the left internal ear; at first there was vertigo, a sensation of heaviness in the brain, and nausea; after a couple of days the patient observed a difficulty in keeping his balance, and in a week and a half there was loss of hearing in the left ear, as well as subjective sounds. There were no signs of any intra-cranial affection, or disturbance of the facial nerve or the other cranial nerves in the middle ear. Perception through the bones of the skull was decreased. The mode of evolution was remarkably slow, the morbid process advancing from behind into the internal ear.

The second case was that of a married woman, aged 34 years, previously in good health, who, five months after syphilitic infection and simultaneously with papulous angina, had an affection of the left ear characterized by subjective sounds, diminution of hearing and, somewhat later, disturbance of equilibrium. The trouble in hearing, which was remarkably influenced by combined antisyphilitic treatment, developed gradually in

the course of some days. In the middle ear there was nothing worthy of notice and no intra-cranial alterations were discovered.

The third case was a man, 29 years old, in whom there appeared, three years after syphilitic infection, paralysis of the right side, with aphasia, due probably to endarteritis of that part of the left Sylvian artery which passed laterally over the anterior perforated substance. During anti-syphilitic treatment these symptoms disappeared. Two years afterward the disease manifested itself in the form of a papulo-squamous syphilide. Seven years after infection he had an apoplectiform attack, with almost complete deafness in the right ear. Two weeks later methodical anti-syphilitic treatment was commenced and the deafness diminished in the beginning, but later remained unaltered, despite a radical treatment with mercury and potassium. Subcutaneous injections of 0.01 gramme ($\frac{1}{6}$ grain) of pilocarpine exercised a more decided influence.

The fourth case was a man, 20 years of age, infected with syphilis a half year previously, who suddenly became completely deaf in both ears. It was impossible to ascertain if troubles of equilibrium had been present. Sounds from a tuning-fork pressed against the skull were perceived in the right ear. After seven injections of thymol-mercury all the other syphilitic symptoms disappeared, but the deafness remained, even after twenty injections of 0.01 gramme ($\frac{1}{6}$ grain) of pilocarpine. Gradually his hearing returned and was perfectly sound after three months had elapsed.

Tubo-Uterine Pregnancy Twice in Succession.—G. EKEHORN reports a case of this kind (*Hygiea*, vol. 57, No. 4) in a married woman of 42, whose first fœtus was viable, but still-born, the next four being normal labors. She then became pregnant July, 1885, and the fœtus died in May, 1886, without being delivered. In August, 1886, fœtal bones were removed through the uterine orifice and fetid abscesses formed, first in the navel then to the right and below it. An opening as large as the fist led into a cavity which was found to contain a fetid and decomposed fœtus. At the following menstrual period the blood escaped only through this fistula, but at the next period it appeared normally. In November, 1891, the patient again became pregnant, and on August 18th the pains commenced, but soon ceased. In the midsummer of 1893, owing to external violence, the fistula, which had healed up, again opened eleven centimetres below the navel and three centimetres to the right of the median line. It communicated with the uterine cavity. Laparotomy was performed and the fœtus and placenta removed, recovery following. This case was certainly one of extra-uterine gestation occurring twice in succession, and probably tubo-uterine. The operation was aseptically performed, and peritonitis did not occur, though the abdominal cavity was opened through the large existing rupture.

Meckel's Diverticulum, with Incarceration.—SVEN LYSANDER observed the case of a girl, aged 11 years, who showed symptoms of acute appendicitis, with meteorism (*Hygiea*, vol. 57, No. 4). Death finally took place in collapse, and at the post-mortem examination the lower part of the ileum, as far as its opening into the cæcum, was found massed together into a ball, livid in color, showing several spots of gangrene, but no perforation. The

cæcum and appendix, lying close by, were quite healthy, and there was no generalized peritonitis. About thirty-five centimetres from its opening into the cæcum, a diverticulum sprung from the ileum, about seven centimetres long and about the same thickness as the ileum itself, somewhat narrower at its base, and dilated into a sac at its apex. At the side of this apex was a string about six centimetres long and about as thick as a small quill-pen, which adhered at its lower end to the mesentery, about twelve centimetres from the point of departure of the diverticulum, a triangle being thus formed in which the ileum situated below had become incarcerated. The bowel beyond the zone of incarceration was distended and its contents fluid.

Uterine and Vaginal Cancer.—B. BERGENHEM (*Eira*, vol. 19, No. 10) operated on a married woman, 60 years of age, in whom the vaginal portio and neighboring parts of the vagina on the right side were occupied by a tumor which was disintegrated and falling to pieces. There was a small induration in the right endometrium; the womb was small and slightly movable. Curettement and cauterization with the Paquelin cautery was performed, and attempts at extirpation by the vagina found impossible. The patient was placed on the left side and an incision made from the sacro-coccygeal articulation to the neighborhood of the anus, then in a curved line to the posterior vulvar commissure. Dissection was made with a blunt instrument in the right ischiatic space to the posterior side of the vagina and uterus, and the incision extended in depth to the sacral ligament. Douglas's pouch was opened, the uterus pulled down and separated after tying the uterine ligaments. The bladder was dissected free, the uterus removed, and the peritoneal cavity closed by means of continuous catgut sutures. The upper portion of the vagina was easily and rapidly removed, although the infiltration in the right parametrium was more extensive. A double piece of iodoform gauze was placed in the upper part of the vagina and was removed through the superior angle of the incision. Recovery was uneventful.

Clinical Notes.

Operation in Puerperal Infection.—CHARLES P. NOBLE, of Philadelphia, states that puerperal peritonitis, due to the rupture or bruising of purulent or other septic accumulations in the uterine appendages existing prior to labor, is not of frequent occurrence (*American Journal of Obstetrics*, June, 1895). In 1891 he reported three cases in which the bruising of pus-tubes during labor had set up peritonitis, and he is aware of two other cases occurring in Philadelphia. From replies to a letter of inquiry on the subject, sent by him to thirty-two eminent American gynæcologists, he finds that but three have operated for peritonitis due to a pus-tube which had antedated labor, and that each of these three operated on only one case. Dr. Lusk, of New York, states that he has seen three cases. The comparative rarity of puerperal peritonitis due to the bruising of pus-tubes is

explained by the fact that women having even a single pus-tube, or other septic accumulation in the pelvis, are usually sterile. Prompt cœliotomy in such cases has given good results.

A second and far more important class of cases, in which the organs are normal before labor, embraces the common form of so-called puerperal fever cases, in which the infection is limited to the utero-vaginal canal, those in which the infection has spread to the broad ligaments through the pelvic lymphatics or veins, and those in which the infection has spread to the peritoneum by way of the Fallopian tubes or the lymphatics. As regards operation, Noble advocates hysterectomy when, in spite of thorough curettement, followed by copious irrigation of the utero-vaginal canal and the use of an iodoform suppository and gauze within the uterus, the septic symptoms increase in severity. In general the less radical measures of treatment should be employed for twenty-four or forty-eight hours, and longer when the symptoms are not urgent. The uterus should be curetted and douched, the patient purged with salines, and quinine, baths, and anodynes given. When the morbid process is seen to go on from bad to worse hysterectomy should be decided on. In cases presenting well-marked local lesions, to be made out by bimanual examination, the indication for operation is more urgent than when no such lesions can be made out. Cases which have gone from bad to worse, and in which the operation is done as a last resort, usually terminate fatally.

Cœliotomy is occasionally called for in cases of true pelvic abscess in the broad ligament or iliac fossa, and resulting from a lymphangitis which has ended in suppuration of the pelvic connective tissue. It is sometimes difficult to determine whether or not the inflammatory process is limited to the connective tissue of the pelvis or whether it is complicated with tubo-ovarian or intra-peritoneal mischief. In such cases an exploratory cœliotomy, to determine the extent of the inflammatory mischief, is desirable. If the broad-ligament abscess is complicated by tubo-ovarian disease or by intra-peritoneal suppuration, the whole trouble can be dealt with through the abdominal incision. If, on the other hand, the morbid process is limited to the connective tissue of the pelvis and has resulted in the formation of a true pelvic abscess, this can be evacuated by a second extra-peritoneal incision, made either in the groin or through the vault of the vagina, as the individual case may require. The personal experience of the author has been such that he recommends it highly in this class of cases. Cœliotomy is not indicated in lymphatic peritonitis, as the morbid process is too widespread to be reached by operation. It has also been followed by a fatal result in cases of general puerperal peritonitis. The only ground for advising such an operation is the possibility that the diagnosis is erroneous. The vaginal route for operation is indicated for large pus accumulations which are found late in the puerperium.

From an experience of seven operations, with four deaths and three recoveries, Barton C. Hirst (*American Journal of Obstetrics*, June, 1895) is strongly disposed to decline to perform hysterectomy in septic infection after labor unless there is evidence of the inflammation having

extended to pelvic structures beyond the womb, fixation of the latter, and the development of inflammatory masses around it. There is not sufficient justification for operation in the first twenty-four hours, and after that it is too late. Diphtheritic endometritis and suppurative and dissecting endometritis are excluded from operative interference. In cases that really demand hysterectomy, by reason of extensive infection of pelvic structures, the outlook must always be gloomy, though the good results are sometimes astonishing. In one of Hirst's cases there was pyosalpinx, ovarian abscess, large and multiple abscesses between the layers of the broad ligaments, and infection of the uterine wall, but the patient made an uninterrupted recovery. In this instance the puerperal sepsis was probably due to a pyosalpinx which existed before pregnancy.

H. J. Boldt (*American Journal of Obstetrics*, June, 1895) performed the radical operation in a case of post-puerperal sepsis, with small multiple pelvic abscess, ovarian abscess, and pelvic peritonitis. The condition of the patient immediately after the operation was so grave that it was not thought that she could rally, but she afterward did so, not having a single unfavorable symptom.

Adaptation of Circular Method of Amputation.—A. G. Miller, of Edinburgh, has successfully employed, in several instances of disarticulation at the knee and elbow, an adaptation of the circular method of amputating, by which a long single flap is secured (*Edinburgh Medical Journal*, July, 1895). The whole point and simplicity of the procedure depends on the well-known tendency to contraction of the soft structures of the flexor aspect of a limb, as compared with the extensor, after the tissues are divided. At the elbow and knee this tendency is increased by extending the joint and thus putting the skin on the flexor aspect on the stretch, while the skin on the extensor surface is completely relaxed.

The method of procedure is as follows: The limb being held out quite straight, a circular incision is made in the ordinary manner below the condyles (1½ inches in the arm and 2½ in the leg), down to the deep fascia. The skin on the flexor aspect (anterior in arm and posterior in leg) at once retracts considerably, making the line of incision oblique. Two small incisions are now made from immediately below the condyles to the original cut. The flexor flap will now still further retract, and, aided by a few touches of the knife, will almost disappear.

The extensor flap is now dissected up as far as the head of the tibia in the leg and to above the olecranon in the arm, care being taken to cut on the deep fascia, and so to reflect the subcutaneous cellular tissue and its contained blood-vessels along with the skin. This flap is loose and ample, being taken from a part where the skin is naturally redundant in order to accommodate itself to the normal action of flexion. (The appearance of the elbow and knee during flexion and extension demonstrates this clearly.) After reflexion of this flap—practically the only one—disarticulation should be performed (on the arm and knee both) from the front, the patella being saved in the latter case It will then be found that there is a long flap on the extensor aspect (anterior at knee and posterior at elbow), with practi-

cally no flap at all on the flexor aspect of the condyles. After the blood-vessels are secured and the nerves drawn out and cut short, this single flap folds nicely over the condyles, being, indeed, in its natural place, and is easily secured by stitches. When healing has taken place, the appearance of the stump is very natural and most satisfactory.

The circular incision requires, at the elbow, to be made only about 1½ inches below the condyles. It is, of course, necessary to have sufficient flap to cover the condyles. If a mark be made 1½ inches below the condyles, with the arm extended, and the elbow be then completely flexed, it will be seen that the anterior portion of the line has slipped up on to the upper arm, while the posterior portion comes up over the condyles quite easily, even with the olecranon in position, which, of course, is dissected out in disarticulation. It is therefore evident that a low amputation and much skin is not necessary for this operation. In disarticulation at the knee the author, by this method, obtains a long, square anterior flap by a single cut, practically speaking, as the two small incisions might be dispensed with, and with little trouble in the way of measurement. The important point is to have the leg fully extended, so as to provide for looseness and length in the anterior flap and immediate and considerable retraction on the posterior aspect. If the lateral cuts below the condyles are not made, then the amputation (after retraction) becomes oblique or oval. After disarticulation the long anterior flap of skin can be stitched, so as to make the cicatrix either transverse (like a long anterior flap operation) or longitudinal (like a Stephen Smith amputation) In this operation the cicatrix is well up on the flexor aspect, and does not adhere to the bone as in circular amputation.

Toxicity of Blood and Urine in Cholera.—F. J. Bosc, of Montpellier, concludes, from experiments with the humors in cholera, that these, especially the blood and urine, may be very toxic and reproduce in animals the most typical symptoms of mortal cholera (*Ann. de l'Inst. Pasteur*, June 25, 1895). The blood-serum in grave cases contains an enormous quantity of a substance which produces effects identical to those obtained by Petri, Pfeiffer, and others with toxins secreted by the comma bacillus, cultivated in an artificial medium. It seems that the symptoms of human cholera depend entirely upon an intoxication by poisons which, secreted in the intestine, penetrate into the blood-current. It may be objected to this latter assertion that the effects produced in rabbits by the intra-venous injection of serum from cholera are not due to the serum itself, but to the development in the blood of the animals of rare bacilli which may exist in this serum. This explanation, according to Bosc, cannot be admitted. The length of incubation is, in fact, in relation to the toxicity of the serum, and becomes almost *nil* in the case of very toxic serum. He has, besides, noted the absence of bacilli from serum taken from the veins in cholera; inoculation in various media of this serum never developed any cultures.

Cure of a Fibroid Tumor by Electricity.—O. S. Phelps, of New York, describes a case of fibroid tumor of the uterus in a 17-year-old girl (*American Medico-Surgical Bulletin*, June 15, 1895). Extreme malnutrition

and subacute periuterine inflammation made operation out of the question. A. H. Goelet, when seen in consultation, in July, advised building up the general health and employing the faradic current to promote absorption of the exudation, with the hope of being able to pursue a radical course of treatment later on. The author began with three applications of the high-tension faradic current every day, each *séance* lasting fifteen minutes, and a systematic course of feeding based upon indications furnished by the microscope, and without the least reference to the patient's appetite or attempt to please the palate. She was sponged daily with ammoniated water, dried with a soft towel, and rubbed with a lotion composed of alcohol 128, quinine 2, sulphuric acid 1, and glycerin 16 parts. The colon was flushed with a gallon of warm water and a vaginal douche given every day. This course was pursued without variation for six weeks before the high temperature and pain began to yield except that after each application of the high-tension faradic current the temperature would fall from ½° to 2° F. (0.72° to 1.12° C.), and the pain would be relieved to about the same extent, both returning before the time for the next *séance*. By the seventh week signs of improvement appeared,—gradual falling of temperature, decrease of pain, and quite visible improvement in nutrition. As the congestion decreased, the tumor and the more solid portions of the exudate were found to occupy much less room than at first appeared, and when the temperature became normal the use of galvanism was begun. The anode was applied to the tumor *per vaginam*, using at first the clay-ball electrode, but later a special electrode devised for the purpose, insulating the clay except at the point of contact with the tumor, thus concentrating the current, while the indifferent electrode was adapted as closely as possible to the growth over the abdomen. Twenty to 30 milliampères of current were used, repeated every fifth day, each application lasting from seven to ten minutes.

The faradic current was continued once a day. Some time in November Goelet examined the patient again and, to his great surprise, found that the exudation had disappeared; the uterus was freely movable and the tumor was reduced in size to one-fourth or less. The patient had gained nearly 40 pounds (18 kilogrammes) in weight and gave other signs of remarkable progress toward a normal state of health. By January 15th the tumor had disappeared, except the merest nodule, and the uterus was freely movable. The uterine cavity then measured 2¾ inches, and there was only a slight endometritis remaining. The patient's weight was 125 pounds (56.8 kilogrammes), she could walk two miles without fatigue, and looked the picture of health.

Rapid Dilatation of the Uterus.—In performing rapid dilatation of the uterus AMAND ROUTH (*Lancet*, June 22, 1895) practices the operation the first day possible after menstruation has ceased, as at that time the cervix is soft and relaxed and partially patent. As it is difficult to dilate a non-secreting cervix, he induces secretion by having a wool tampon soaked in glycerin introduced into the vagina against the external os uteri, two hours before operation. The addition of some cocaine to the glycerin may possi-

bly allay spasm. If the cervix is likely to be unusually rigid, he passes into the cervix and, if possible, through the os internum, a strip of antiseptic gauze, soaked in glycerin and iodine, six or eight hours before the operation, or even over night. A few bougies may be passed if necessary to enable this to be done. These aids are almost always sufficient, but in 1 or 2 per cent. of cases it may be impossible to pass the little finger, and the uterus can be swabbed out and packed fairly tightly with gauze for twenty-four hours, when it will easily admit the finger. A tent would here be absolutely contra-indicated, and by these aids the author has been able to entirely dispense with tents for the past five years, in both hospital and private practice.

James Braithwaite, of London (*British Medical Journal*, June 29, 1895), also recommends dilatation of the cervix on the last day of the menstrual period, instead of between the periods, as is the almost universal practice. Many years ago he accidentally discovered that if the dilatation is done just when the discharge has ceased the parts are perfectly elastic and soft, and has very little resisting power. Hegar's dilators can, in many cases, be passed in, one after the other until No 17 is reached, admitting the passage of a medium-sized index finger. An anæsthetic is necessary, as the patient will not remain sufficiently quiet. Two Sims's hooks close together, so that the handles are held as one, are better than a vulsellum. They hold better, and are less likely to scratch the operator's finger. The process should be done leisurely, but it does not take above twenty minutes. The smaller sizes of the dilators should have the terminal inch a little curved forward and less in size, so as to enter more readily. This plan opens up quite a vista of utility in other cases than those of dysmenorrhœa; for instance, it is often next to impossible to examine with the finger the interior of the uterus of a sterile woman over 40 years. The parts absolutely refuse to dilate sufficiently. But, by dilating on the last day of the period it can be done very easily. Every uterus does not yield so readily as described and, indeed, now and then a tough cartilaginous os internum is met with which almost refuses to yield at all; but even this is more dilatable than it would be in the intermenstrual interval.

Wound of the Pleura.—S. H. House, of Grimsby, records a case of perforating wound of the right pleura in a boy of 4 years, due to a fall down stairs upon some broken crockery (*Lancet*, June 29, 1895). The wound was seven inches long across the back, extending through the muscles to the spine at the level of the ninth dorsal vertebra, and on the right side, reaching to the seventh intercostal space, in which there was a wound through the pleura parallel to the ribs an inch and a half long, through which air whistled in and out of the pleural cavity. The lung was thoroughly collapsed. The only covering during a period of three hours was a dirty blanket. When brought into hospital on April 25th the pulse was very feeble, 152. As quickly as possible all parts of the wound were thoroughly cleansed with 1 in 40 carbolic lotion, care being taken to prevent any entering the pleural cavity. There being very little hæmorrhage the wound was sewed up at once with silk-worm-gut sutures, drawing the skin

over the wound in the pleura, and finishing with a firm dressing of cyanide gauze and alembroth wool. During that night the child was restless, but had some snatches of sleep. Respiration varied from 40 to 50. The temperature was 99° F. (37.2° C.) and the pulse 130 to 150 and over. The next day the child was less restless; he was propped up in bed and in the afternoon he joined in some singing which he could hear from another ward. The pulse was 130 and the respiration 38. That night the temperature was 100° F. (37.8° C.), the only time in the progress of the case it was above the normal; the patient slept quietly all night. The child made an uninterrupted recovery. Respiration on the third day was 30 and the pulse 120. He ate and slept well. The wound healed by first intention, and the stitches were removed on May 1st, when the breath-sounds could be heard at the base (right). On May 20th breath-sounds could be heard all over the right side. The child was up and running about.

Albuminuria in Typhoid Fever.—Louis Leocoq has studied the prognostic value of albuminuria in a large number of cases of typhoid fever seen by him (*Jour. de Méd. et de Chir.*, June 25, 1895). It is known that in this disease albuminuria is almost constant, when carefully tested for. That appearing at the end of the first or beginning of the second week is scanty and lasts but a few days, influencing in no way the progress of the fever. When albuminuria appears late, however, it is a graver symptom; in the third or fourth week it announces that the kidney is affected and no longer properly performs its functions, and that the toxic principles of the fever can no longer be eliminated with ease. Uræmia is here to be feared, and in the author's own cases the mortality where late albuminuria appeared was 66 per cent. However, the nephritis must not of necessity be considered as the cause of the gravity of the disease, but as being always one of the symptoms and sometimes the only symptom of this gravity. The quantity of albumin in the urine cannot aid in the prognosis; for while certain patients, excreting 0.4 gramme (6 grains) per litre (quart), die, others, excreting 2.5 grammes (38½ grains) per litre during a long period, recover. On the other hand, the quantity of urine indicates the gravity in a certain manner. If the amount diminish and but a few hundred grammes are eliminated, the patient will die; if he continue to urinate freely, or the quantity increases, the chances of recovery are good. The author finds in this fact an indication for the cold bath as being the most powerful diuretic, and therefore the treatment of choice.

Chronic Ulcers.—With a sharp knife cut out completely the base and border of the ulcer, removing all cicatricial tissue. Stop hæmorrhage by elevating the limb and exposing it to cold air, ligating larger vessels if necessary. Cover the surface with thin grafts, and dress with salt solution, using extreme care to avoid pressure. Redress after forty-eight hours to remove sloughing particles, and then dress daily. (Emmet Rixford, *Occidental Medical Times*, June, 1895.)

Recent Suggestions in Therapeutics.

Argonin.—A. LIEBRECHT, of Breslau (*Ther. Monats.*, June, 1895), has given the name of *argonin* to a combination of *nitrate of silver* mixed with a *sodium* compound of *casein* and precipitated by *alcohol.* MAYER finds that it is easily soluble in hot water, and with difficulty in cold water, but a 10-per-cent. solution can be prepared. It is readily soluble in *albumen*, and a 10-per-cent. solution in *serum* can be made. It is of considerable strength as an antiseptic, though the watery solutions are less powerful than *silver nitrate* or the albuminous solutions. It does not irritate the mucous membrane.

Belladonna to Overcome the Catarrh Caused by Potassium Iodide.—GEORGE COHEN, of Hull, Eng. (*Lancet*, July 13, 1895), has been able in three cases to stop the catarrh following the use of 10 grains (0.65 gramme) of *iodide of potassium* and ½ ounce (16 grammes) of *water* by adding to this mixture 5 minims (0.32 gramme) of *tincture of belladonna* per dose in order to reduce the salivary secretion. It also counteracts the so-called depressant action of the potassium.

Cholera.—In the treatment of cholera ELMER LEE, of Chicago (*Journal of the American Medical Association*, June 22, 1895), proposes flushing out the alimentary canal with large quantities of water, from 1 to 10 quarts (litres) of warm, pure *water* containing a little *peroxide of hydrogen* by the mouth being administered daily. The portion of bowel accessible by the rectum should be washed out three or four times a day, according to circumstances. HOLLISTER has used *tannin mixture* and strong *cinnamon-tea*, combined with copious injections of water, with good effect, during four epidemics in the United States.

Citrophen.—This is a combination of *citric acid* and *phenetidin*, first obtained by Israel Ross. *Citric acid* being tribasic, three groups of *phenetidin* are required to saturate it; hence a molecule of *citrophen* contains two more molecules of *phenetidin* than does *phenacetin* and *lactophenin.* It is a white powder, agreeable to the taste, and soluble in forty times its weight of cold water and fifty times its weight of hot water. It can be used subcutaneously and in solution. BENARIO (*Deut. med. Woch.*, No. 26, 1895) has found it to be well supported as an antipyretic and antineuralgic, in doses of 0.5 to 1 gramme (7½ to 15 grains). The daily amount can be increased to 6 grammes, if necessary. Benario has used it in typhus fever, the fever of phthisis, migraine, and neuralgia, with satisfactory results.

Faceache.—W. M. CAPP, of Philadelphia (*Medical News*, June 15, 1895), recommends the insufflation of *sodium chloride* into the nasal cavity for the relief of acute pain in the face and head. In five cases of faceache from decayed teeth the pain disappeared at once upon the contact

of pulverized *table-salt* with the mucous membrane of the nose, a glass nose-insufflator being used. In a number of cases of severe headache, without regard to cause, the remedy was equally satisfactory, and also in a case of pain from a furuncle in the external auditory canal, and in another of pain from excessive use of the eyes. The method was first recommended by George Leslie (*Edinburgh Medical Journal*, January, 1890.).

Facial Erysipelas.—H. DE BRINON, of Moulins, has had excellent results from the treatment of erysipelas of the face by the *sublimate spray* (*Concours Méd.*, June 22, 1895). Instead of an *ethereal solution* of 1 to 100, as recommended by Talamon, he uses a solution of 1 to 1000. The burning sensation complained of when the former is employed is not experienced, while the method remains equally efficacious.

Flatulence.—When associated with pain after food and a coated tongue, indicating gastritis, give the following: *Potassii bicarb.* vel *sodii bicarb*, 2 drachms (8 grammes); *sp. ammon. arom.*, 1½ fluidrachms (6 cubic centimetres); *liq. strychninæ*, 30 minims (2 cubic centimetres); *sp. armoraciæ co.* vel *sp. cajuputi*, 1½ to 2 fluidrachms (6 to 8 cubic centimetres); *sp. chloroformi*, 1 fluidrachm (4 cubic centimetres); *infus. calumbæ* vel *gentianæ co.* (fresh), ad 6 fluidounces (186 cubic centimetres). M. ft. mist. A sixth part three times a day between meals. The alkali and bitter clean the tongue and correct the disordered state of the gastric mucous membrane. The strychnine braces up the muscularis, whilst the carminatives, horse-radish or cajuput, and chloroform excite reflex contractions of the stomach. If the pain in the stomach is great, add 1 fluidrachm (4 cubic centimetres) of *Schacht's liquor bismuthi* to the mixture, and, in addition, prescribe the following pill: *Acid. carbolic.*, 12 grains (0.78 gramme); *zinci valerianat.*, 20 grains (1.3 grammes); *aloinæ*, 6 grains (0.39 gramme); *ext. nucis vom.*, ¼ grain (0.016 gramme), vel *strychninæ*, $\frac{1}{30}$ grain (0.002 gramme); *oleoresin. capsici*, 1 drop. M. ft. pil. xij. One pill night and morning. The aloes to be omitted when the bowels act sufficiently; but in the great majority of cases constipation is present, due to torpor or want of tonicity of the colon, producing intestinal flatulence. When there is much tendency to spasm, give ¼ or ⅓ grain (0.016 or 0.02 gramme) of *extract of belladonna* in addition. For violent spasmodic attacks: *Sp. cajuputi*, *sp. ammon. arom.*, *sp. chloroformi*, each ½ fluidounce (16 grammes). M. ft. mist. "The antispasmodic mixture." One teaspoonful in a wineglassful of water every half-hour or every quarter of an hour until relief is obtained. This should be kept on hand by the patient. (STEPHEN MACKENZIE, *London Practitioner*, July, 1895.)

Furuncle.—To prevent secondary attacks, so frequent in these cases, wash with a 1 to 1000 solution of *sublimate;* then—with *carbolic acid*, 1 part; *camphor*, 2 parts—wash the healthy skin in the neighborhood of the primary furuncles, wipe the surface carefully with absorbent cotton, and paint with *traumaticin* or *steresol.* When this has been thoroughly

Furuncle (*continued*).

applied treat the furuncle as may be indicated. Apply a new coat of the varnish from time to time, and warn the patient of the necessity of not rubbing the affected part, of keeping the nails clean, of frequently washing the hands in an antiseptic solution, etc., in order not to carry the staphylococcus to another part of the body; also sterilize clothing brought in contact with the affected part. (DE CRÉSANTIGNES *La France Méd.*, June 14, 1895.)

Green Diarrhœa of Infants.—As soon as the first symptoms appear, BARATIER, of Jaugny, France (*Trib. Méd.*, July 17, 1895) gives a dose or two of ordinary purgative tea, and, when it has acted, he suppresses all food or drink and gives regularly every two hours 6 tablespoonfuls of the following: *Fat-bouillon*, 1000 grammes (32 ounces); *glycerin*, 100 grammes (3¼ ounces). The bouillon is made fresh every day, with 1 kilogramme (2⅛ pounds) of beef-bones (no meat or vegetables) in 2 litres (quarts) of water, with a pinch of salt. It is boiled over a good fire for four hours until it is reduced to half the quantity, then allowed to cool, the fat skimmed off, and the *glycerin* added. This is essentially a *glycerophosphate* treatment within the reach of all. In the author's hands it causes the disappearance of the diarrhœa in a day or two; but it is continued three or four days and then alternated with milk for about a week, when it is discontinued.

Insomnia of Neurasthenia.—CLAUS (*La Flandre Méd.*, June 20, 1895) considers *trional* as the best and least dangerous of the hypnotics in the insomnia of neurasthenia. It should be administered before retiring, in varying doses, according to the degree of insomnia and the age of the patient; ordinarily 1.5 grammes (23¼ grains) is sufficient. Of thirty cases observed by him the results were uniformly favorable.

Malaria.—VERRIER (*La France Médicale*, June 28, 1895) advocates the use of local douches in the treatment of intermittent fevers and malarial cachexia. He calls attention to the fact that a too powerful local douche, instead of being antihyperæmic, produces a congestive effect by the prompt and energetic reaction which follows it; while a too weak general douche produces congestion instead of revulsion. If an antipyretic or antiperiodic effect is desired, the douche should be a general one, very strong, lasting from fifteen to twenty seconds, and given a quarter of an hour before the expected febrile attack. In such a case the douche exercises a short and very strong perturbatory action on the nervous system, driving the blood from the periphery toward the centre, and this movement of concentration is immediately followed by an easy and strong reaction, causing the blood to flow toward the periphery. A single such douche, properly administered, is often sufficient to cut short a regular intermittent fever, no matter what its origin.

MOSCUCCI (*Gaz. deg. Osp.*, No. 66, 1895) treated two cases of malarial fever by means of *analgen* in daily doses of 1 to 2 grammes (15½ to

31 grains), administered a few hours before the attacks. The splenomegalia present was cured in a month by means of an *ether* spray applied over the spleen, the tumor rapidly diminishing in size and the pain immediately disappearing.

Malarial Hepatitis.—A. ROBIN, of Paris, finds that, while sulphate of quinine is often without effect in congestion of the liver of malarial origin, quinquina gives good results when associated, in a prolonged course of treatment, with arsenic, iron, and hydrotherapy (*Bull. Gén. de Thér.*, June 30, 1895). He lays down the following plan of treatment: 1. *Arseniate of sodium*, 0.05 gramme ($\frac{7}{8}$ grain); *water*, 300 grammes ($9\frac{1}{2}$ fluidounces). A tablespoonful morning and evening. 2 Yellow and red *cinchona powder*, each 4 grammes (1 drachm). To make 30 powders, 1 powder to be taken daily in one or two doses, in black coffee, preferably after meals; or, if not well supported, 8 or 10 pills daily, each pill containing gray and yellow *cinchona powder*, each 0.12 gramme ($1\frac{7}{8}$ grains); *extract of quinquina*, 0.25 gramme (4 grains). Make 60 such pills. 3. Every morning a cold douche, commencing by a jet directed to the spine and ending by a powerful one on the liver and spleen. This treatment is continued for a month, when the arsenic and quinquina are replaced by an iron preparation for a month, the former treatment being again resumed and alternated monthly until all symptoms have disappeared.

Operation in Jaundice from Obstruction.—W. RUSSELL, of Edinburgh, discusses the advisability of operation in jaundice from malignant obstruction, and expresses the opinion that such an operation is warranted in cases in which the obstruction can be located below the cystic duct (*Edin. Med. Jour.*, July, '95). The presence of duodenal lesion does not contra-indicate operation, nor does even clear involvement of the liver, as long as distension of the gall-bladder shows that the hepatic duct is not blocked. The most suitable cases for operation are naturally such as the one reported by him in which the lesion was confined to the head of the pancreas.

Opium Poisoning.—C. D. SIMMONS, of Dutch Town, La. (*Medical News*, June 22, 1895), used hypodermatic injections of strong black coffee in a case of accidental opium narcosis in a child 5 months old, injecting 20 minims (1.3 grammes) every ten or fifteen minutes. At the same time artificial respiration and titillation with the ends of the fingers over the ribs were kept up, and in six hours the little patient was out of danger.

Oxygen in Diseases of the Air-Passages.—G. J. PRESTON, of Baltimore (*Journal of the American Medical Association*, June 15, 1895), shows by a series of experiments on animals that the percentage of hæmoglobin in the blood can be largely increased by the inhalation of pure oxygen; and from this fact he urges a full and scientific trial of the method in pneumonia, acute bronchitis, pulmonary emphysema, pulmonary tuberculosis, and diseases obstructing the air-passages.

Typhoid Fever.—J. S. CARPENTER, of Pottsville, Pa. (*Therapeutic Gazette*, June, 1895), gives the details of five cases of typhoid fever from an epidemic of forty treated by him in which he used *guaiacol* as an antipyretic. A maximum dose of 35 drops was employed, the average satisfactory dose being from 15 to 20 drops. When one application fails to cause a reduction of temperature within two hours, a second one may be made; and, according to the author, a reduced dose will effect as much lowering of body-heat under such circumstances as is desirable. His best results were obtained when the drug was combined with cold-water baths or spongings.

Monographs Received.

The editor acknowledges, with thanks, the receipt of the following monographs:—

Annual Reports of the Managers and Officers of the State Hospitals of New Jersey for the year ending October 31, 1894, **B. D. Evans**, Medical Director, Trenton, N. J.——Fifteenth Report of the State Board of Health of Wisconsin, 1893-1894, **W. O. B. Wingate**, Secretary, Madison, Wis.——Annual Report of the Department of Health of the City of Chicago for the year ending December 31, 1894, **Arthur R. Reynolds**, Com., Chicago, Ill., 1895.——Wills Eye-Hospital Reports, vol. i, No. 1, **Charles A. Oliver** and **Conrad Berens**, Ed. Com., Philadelphia, 1895.——History of the Treatment of Spondylitis and Scoliosis by Partial Suspension and Retention by means of Plaster-of-Paris Bandages, by **Lewis A. Sayre**, New York, 1895.——Plaster-of-Paris, Wood, Aluminium, and other Spinal Supports, by **A. M. Phelps**, New York, 1895.——Transactions of the Medical Association of Central New York, Twenty-seventh Annual Meeting, Buffalo, N. Y., October 16, 1894.——Comparative Microscopical Studies of the Ovary, by **Francis Foerster**, New York, 1894.——External and Internal Use of Guaiacol, by **J. M. Anders**, Philadelphia, 1895.——Aseptic Prophylaxis of Asiatic Cholera; Arsenization, by **Reginald Barkley Leach**, Paris, Texas.——Normal Absorption of Fat, and the Effects of the Extirpation of the Pancreas on it, by **Vaughn Harley**, London, 1895.——Remarks on Ectopic Gestation, by **Francis Foerster**, New York, 1895.——Prevention and Treatment of Ophthalmia Neonatorum, by **Charles H. May**, New York, 1895.——Proceedings of the American Microscopical Society, Seventeenth Annual Meeting, Brooklyn, August, 1894.——Some Minor Studies in Nerve-Cell Degeneration as presented by a Case of Localized Cerebral Atrophy, by **Thomas P. Prout**, Morris Plains, N. J.——Tubal Mole Pregnancy, by **Hiram N. Vineberg**, New York, 1895.——Ripening of Immature Cataract by Direct Trituration, by **Boerne Bettman**, Chicago, Ill., 1895.——Diagnosis of the Diseases of the Accessory Sinuses and their Treatment, by **Robert C. Myles**, New York, 1895.——Nuovo Enterorafo, per il **Dott. Adolfo Brucchietti**, Rome, 1895.——Case of Acute Delirium, by **Thomas P. Prout**, Morris Plains, N. J., 1894.——Imperforation of the Rectum, by **Geo. Ben. Johnston**, Richmond, Va.——Surgical Clinic, by **Augustus C. Bernays**, St. Louis, Mo., 1895.——Vaginal Cœliotomy, by **Hiram N. Vineberg**, New York, 1895.——La Diphtérie de l'Adulte a l'Hôpital Lariboisière, par **A. Gouguenheim**, Paris, 1895.——The Use of Scissors in Excision of the Tonsils, with Reference to a New Instrument, by **Arthur Ames Bliss**, Philadelphia, 1895.——Thymus Volumineux chez un Enfant, par **C. Bayer**, Prague, 1895.——De l'Importanse Sociale des Villes d'Eaux, par le **Dr. Grellety**, Macon, France, 1895.——Some Points in the Etiology, Pathology, and Indicated Treatment of Diphtheria, by **A. A. Young** Newark, N. J.——Suprapubic Cystotomy for Calculus of the Bladder, by **A. H. Meisenbach**, Chicago, Ill., 1895.——Idiosyncrasy and Drugs, by **G. Walter Barr**, Keokuk, Iowa, 1895.——On Movable Kidney, by **George Ben. Johnston**, Richmond, Va., 1895.——Treatment of Laryngeal Tuberculosis by the Application and Submucous Injection of Creasote, by **Walter F. Chappell**, New York, 1895.——An Anomalous Female Urethra, by **William A. Edwards**, San Diego, Cal., 1895.——Amputation of the Metacarpal Bone in Continuity, for Injuries of the Middle and Ring Fingers, by **Claude A. Dundore**, Philadelphia, 1895.——Improved Double Retractors, by **Seth Scott Bishop**, Chicago, Ill, 1895.——Zur Radicaloperation der Inguinalhernien in Kindesalter, von **Wilhelm Bittner**, Prague, 1895.——Intra-peritoneal Hæmorrhage due to Tubal Pregnancy, by **John W. Taylor**, Birmingham, Eng., 1895.

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(End of Editorial Department of Journal for August, 1895.)

DR. ELMER LEE concludes an able article, which appeared in the *Journal of the American Medical Association*, June 22, 1895, on the treatment of Asiatic cholera, with the following emphatic statement:—

"The result of prolonged reflection, covering many years, and the observations resulting from personal experience in the cholera epidemic in Europe of 1892, is the conviction that there is provided in the laboratory of the universe a remedy which surpasses the results of human ingenuity as much as does the sun surpass in brilliancy the light of the artificial lamp. The all-pervading and all-wide remedy, the greatest product of omniscient nature's laboratory, which alone can cope with this pestilential disease of the human race, is nothing more and nothing less than the unmatched, unmatchable H_2O. Pure water is absolutely the only trustworthy cure for cholera, and if it came at a great price it would probably be more greatly valued. The human organism is so constituted that, if it is assisted by H_2O, every morbid element may be eliminated out of its domain. The acutely-poisoned body quickly recovers its equilibrium and its harmony of action as soon as the processes of elimination can remove the invading poison. In the construction of the mucous lining of all the accessible cavities and channels it is prepared by an undiscernible law to successfully resist the entrance of every form of organism. The products of organic action alone are able to pass into the blood. If sufficient quantities of pure water, of a suitable temperature, are introduced into the body through the natural channels, it is actually possible to wash morbid products, as well as organic forms of life, out of the human body. The mouth gives entrance to the causative germs in Asiatic cholera. That is quite conclusively established. The locality of the development and formation of the toxin in the earlier stages is determined to be in the upper end of the small intestine; and from experience, as well as from the powers of reflective analogy, there is no doubt that the system can be saved from death if the morbid entity, the germ, is literally deluged away from the alimentary canal by the copious use of a remedy that cannot be of the slightest danger to the victim. The amount of water to be used varies in different cases. It is impossible to use too much; it is possible to use too little From the earliest moment that the patient is seen the proposition should be, first, wash the whole alimentary canal with pure water; wash the lower portion by introducing irrigations of warm soap-suds or merely warm water into the colon sufficiently frequently and sufficient in quantity to cleanse that portion of the bowel effectually. The frequency of washing that portion of the bowel which is accessible from the rectum should be one, or two, or three, or four times a day, according to circumstances. At the same time from one to ten quarts of warm, pure water, mildly medicated with peroxide of hydrogen or hydrozone, should be administered at regular intervals, during the day, as the prescribed remedy by the mouth. If the patient vomit, very well. Immediately re introduce the quantity of water that was vomited. No harm can be done in any case, and, if it is possible to save life, it is possible to save it through this method."

Creosote Carbonate (Creosotal)—Von Heyden—is the very best form of beech-wood creosote for administration to consumptives. It contains 92 per cent. of the purest beech-wood creosote in chemical combination with 8 per cent. carbonic acid. Its action is non-caustic and non-irritating to the mucous membrane of the digestive organs, contrary to that of ordinary creosote; and it will agree perfectly with the most sensitive stomachs.

One of the very first effects of Creosote Carbonate is an increase in appetite and a consequent gain in strength; the cough diminishes perceptibly, and finally the ulcerative process ceases and cicatrization sets in. The weight of the patient increases continuously, and sometimes at a very rapid rate.

THE

Universal Medical Journal.

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Selections from Society Proceedings.

BELGIUM.

SOCIÉTÉ BELGE D'OTOLOGIE ET DE LARYNGOLOGIE.

Adenoma of the Hard Palate.—M. BECO read a paper upon this pathological rarity. The term "adenoma," under which the affection was first described, corresponds to the origin of the tumor and its benign clinical appearance; it is not always exact, however, for often the growth is found to be of a mixed character, as adenosarcoma, and sometimes it even shows malignant characteristics. It is usually situated to the left of the vault, and is more frequently met with in women than in men. It does not affect the general health, and does not recur after extirpation if still encapsulated when removed. The growth is usually met with between the ages of 10 and 30. M. Beco's patient was a woman aged 22, and the tumor occupied the right half of the hard palate. It had been first noticed some two years before, and had grown slowly and painlessly until it had reached the size of a plum. It projected into the mouth and rested on the tongue. It was removed in November, 1894, and its seat cauterized with chloride of zinc and the thermo-cautery. Recovery was complete in twenty days. On section the tissue of the growth was found to have the granular, reticulated appearance of the ordinary adenoid vegetation or of a parotid gland. The microscope, however, showed that the tumor, although clinically benign, had already undergone transformations which would place it under the head of adenocarcinoma.

Relation between the Sexual Organs and Laryngeal Affections in Women.—M. BAYER has recently had occasion to observe a case which confirms his views as to the relation of the sexual apparatus to the voice in women. The patient was a married woman, 34 years old, who showed all the symp-

toms of laryngeal stenosis,—dyspnœa, aphonia, cough, expectoration, and œdema of the lower extremities,—in short, a typical advanced tuberculosis. Laryngoscopical examination revealed ulcerating tuberculous laryngitis with tumefaction of the epiglottis, the arytenoids, and the interior of the larynx. The stenosis was so great that tracheotomy was thought soon to be necessary. The patient was about to enter the clinic of the author, when abortion occurred and he was called to see her. She had omitted to tell him that she was three months pregnant. Eight days after the miscarriage he was surprised to find that the larynx was no longer swollen and that tracheotomy was not necessary. He recommended her to follow his method of treatment for tuberculosis (creasote, 20 per cent., in vasogen, with hyperalimentation) together with hygienic measures. It appears from this case that pregnancy may exercise the same influence on laryngeal affections as does menstruation, and inquiry as to the condition of the sexual system should always be made when rebellious laryngeal symptoms appear.

ACADÉMIE ROYALE DE MÉDECINE DE BELGIQUE.

Influence of Sulphate of Strychnia on the Heart.—LA HOUSSE, from experiments on dogs, demonstrates that sulphate of strychnia, in large or small doses, causes slowing of the heart, without any preliminary acceleration, even when the heart is previously atropinized. The drug paralyzes, from the outset, the intra-cardiac motor centres, and also (though only in large doses) the terminal fibres of the vagus, probably without previously exciting them. The slowing of the heart is not due, as Mayer states, to excitation of the moderating bulbar centre, but, in la Housse's opinion, to paralysis of the intra-cardiac motor centres.

Cysticercus in the Cardiac Muscle.—FIRKET found, at an autopsy, a *Cysticercus racemosus* in the cardiac muscle. Nothing in the clinical examination of the patient would have enabled a diagnosis to be made. Microscopical examination showed that this cysticercus was related to the *Tænia solium*, its irregular form being due, in the author's opinion, to unequal pressure upon the vesicle, and also to a diminution in its vitality. It is the first time that this parasite has been met with in the nervous centres, and the case is regarded as an extremely rare one.

FRANCE.

ACADÉMIE DES SCIENCES.

Chloride of Lime in Venomous Wounds.—G. PHISALIX and G. BERTRAND, from a series of carefully-conducted experiments, conclude that solutions of chloride of lime, advocated for the bites of venomous serpents, possess no general immunizing action, but purely a local effect. The agent may destroy the venom at the spot, but its chief action is to cause mortification of the tissues and prevent absorption of the toxic substance. It must therefore be concluded, from a practical stand-point, that injections

of chloride of lime, made at other points than that of the wound, should be avoided; and, if the antidote be used, it should be injected into the region of the wound, deeply, rather than immediately under the skin.

CALMETTE, on the contrary, claims that chloride of lime prevents the poisoning of the system when injection is made deeply into the tissues in the region of the bite. Many other experimenters have, according to him, observed the same results. Injections of a solution of purified hypochlorite of lime—about 0.8 litre (⅘ quart) of chlorine to 1 litre (1 quart)—do not give rise to eschars, either in man, the horse, dog, rabbit, or donkey; they do sometimes cause them in the guinea-pig.

SOCIÉTÉ DES HÔPITAUX.

Acute Thyroiditis after Influenza.—The thyroid gland usually escapes involvement in the infectious diseases, but GALLIARD reports a case in which acute inflammation of the right lobe of the thyroid followed an attack of influenza. Suppuration was at first feared, but the thyroiditis ended in resolution. The patient, aged 40 years, had never had goitre. She was exposed to cold during menstruation and soon after developed the thyroiditis. After resolution tachycardia and palpitation were observed, but the thyroid swelling did not return.

Infection of Wet-Nurses by Child.—LE GENDRE gives the curious history of an infant suffering from a rebellious seborrhœic eczema, whose first wet-nurse was addicted to the use of liquor. A second nurse suffered from an abscess of the breast soon after she began to nurse the child, and the latter developed an intractable diarrhœa, the general condition becoming so bad that another nurse was taken. The third nurse also soon developed a phlegmon of the breast, which, fortunately, ended without suppuration. The infant died in a short time, from general infection. The author believes that the child, who had stomatitis, suffered from an infectious condition of the digestive tract, and that this infectious condition was the cause of the seborrhœic eczema as well as the mammitis of both nurses. The eczema here was the consequence of an auto-intoxication originating in the digestive organs.

SOCIÉTÉ D'ANATOMIE ET DE PHYSIOLOGIE, BORDEAUX.

Bacteriology of Vulvitis.—In two cases of simple muco-catarrhal vulvitis in girls of about 10 years of age, observed by COYNE and AUCHÉ, bacteriological examination revealed the absence of gonococci and the presence of several varieties of microbes,—the coli bacillus, staphylococcus albus, and the streptococcus pyogenes. The first was found in only one of the cases, in which the linen of the child was soiled by fæcal matter. The staphylococci were rare in this case, but frequent in the other one. Streptococci were numerous in both cases; upon one examination they were but slightly virulent, and upon another they were sufficiently so to determine an erysipelatous redness of the entire ear of a rabbit, while intra-venous injection caused death in six days. The authors are inclined to attribute the vulvitis

to these micro-organisms, though they do not affirm this as a fact, since, in cases in which cleanliness is not observed, numerous microbes may be present in the parts.

GERMANY.

BERLINER MEDICINISCHE GESELLSCHAFT.

Pneumonia Terminating in Induration.—A. FRANKEL discussed, from an anatomical and clinical stand-point, the subject of pulmonary inflammation ending in induration. Ordinarily acute and subacute inflammations are superficial, simply involving the alveoli for a certain period; however, there are exceptions to this rule, the inflammation sometimes ending in induration. Certain authors deny such a termination of the disease, but Fränkel believes that, though it occurs but rarely, perhaps in only 1 per cent. of the cases, it nevertheless does occur. Anatomo-pathologically the surface of the lung in indurated pneumonia is found, upon section, to be smooth and its tissue resistant, while in ordinary fibrinous pneumonia it is granular with friable tissue. In the indurated variety the surface of the section sometimes shows a peculiar transparency, with characteristic yellow specks, due to the collection of cells, which have become fatty. Under the microscope the alveoli are seen to be blocked up by connective tissue resembling polypi, containing vessels and by their structure recalling the process of organization of thrombus.

The clinical symptoms of induration are continuation of fever, persistent dullness, and progressive retraction of the thoracic wall. As a general rule these signs lead the observer to suspect a pulmonary abscess or empyema, but induration must also be thought of, and not confounded with slow resolution; in the latter case dullness persists, but not the fever, which in induration is atypical, lasting weeks, and in broncho-pneumonia even months, gradually disappearing. The murmur diminishes and grows softer, crepitant râles become coarser and less frequent, and finally retraction of the thorax takes place. The duration of the process is variable, the author having observed two cases terminating fatally on the sixteenth and twentieth days, in which induration was found at autopsy to be complete. Both patients were young; so that it is incorrect to suppose that induration only occurs in elderly persons.

Fränkel does not attribute this rare termination of pneumonia to mechanical irritation or disturbance of lymphatic functions from resorption of the exudate, as do some authors, but to a bacterial cause. It is observed after fibrinous pneumonia, broncho-pneumonia, and pneumonia due to influenza; and in these cases, when fever persists, an examination of the sputum will settle the question as to tuberculosis. It sometimes occurs after pneumonia caused by the aspiration of food, but is rare in acute and subacute caseous pneumonia, though Fränkel has seen two such cases. The prognosis is favorable in the latter variety, but not so in lobar and lobular pneumonia.

Spasmodic Cerebral Diplegia.—OPPENHEIM presented two patients,—a woman aged 31 years and her daughter aged 10,—both suffering from spasmodic cerebral diplegia. The mother had, from infancy, showed motor disturbances of the muscles of the trunk, limbs, tongue, vault of the palate, and pharynx, the most marked at the present being at the site of the cranial nerves. Although the patient is intelligent and hears everything, she is unable to utter a sound, owing to spasmodic contraction of the lips and jaws, though the electrical excitability of the muscles of the lips and tongue is preserved. Deglutition is effected slowly, as are the movements of the hands. The same symptoms, though less marked, may be observed in the daughter, who is hardly able to speak, and then but unintelligibly, as do patients affected with bulbar paralysis. Oppenheim believes that there exist in these cases bilateral lesions of the motor region of the brain, acquired in infancy. Ordinarily in such patients meningeal hæmorrhage or meningo-encephalitis gives rise to functional disturbance of the corresponding regions of the brain.

GREAT BRITAIN.

BRITISH MEDICAL ASSOCIATION.

Aseptic and Antiseptic Precautions in Private Midwifery Practice.—A discussion upon this subject was introduced by DR. HERMAN, Obstetric Physician to the London Hospital, who submitted three questions for consideration: 1. What is puerperal fever? In his opinion it is a fever caused by the inoculation of septic organisms, which are not the same as saprophytes, but are descended from those usually associated with putrefactive changes. Those micro-organisms require a special soil for their development, and the generative passages during and subsequent to delivery offer a suitable field for their growth. Complete sterilization, or the destruction of all micro-organisms, is what should be aimed at, but it is not practicable in midwifery practice. 2. How can puerperal fever be prevented? An effort must be made to keep septic germs from the patient. This is to be achieved by asepsis, or perfect cleanliness, and by antisepsis, or the employment of germicides, and the one considered most efficient by Dr. Herman is corrosive sublimate, it being the most portable and, upon the whole, the most trustworthy. The external antiseptic precautions consist of the purification of the attendants' hands by washing with soap and water, the use of the nail-brush, and soaking in an antiseptic solution; the boiling of all instruments used; scrupulous cleanliness in the dress of nurse and medical attendant; and the use of clean absorbent material, such as antiseptic cotton-wool, instead of napkins and sponges. The internal precautions are the restriction of vaginal examinations to the fewest possible, the washing of the genitals, the use of an antiseptic lubricant, and vaginal antiseptic douches during and after delivery and throughout the puerperium. The use of the vaginal douche may do harm, and experience has shown that women whose labors are normal do as well without vaginal douches as with

them; but in abnormal cases, as in lacerations or in cases in which intra-uterine investigation is required, not only vaginal but intra-uterine douches are necessary. 3. What are the differences regarding the prevention of puerperal fever between hospital and private practice? In answering this Dr. Herman said that in private practice there is less danger, and that antiseptic vaginal douches before delivery and during the puerperium may be dispensed with except in cases in which the discharges are unhealthy or in which extensive lacerations exist. As a general rule the antiseptic douche immediately after labor was advocated and should be given by the medical attendant. In private the nurse, it was averred, received less guidance, for the rules of a hospital are not always before her. To make up for this some obstetric physicians give their nurses a printed paper of directions to be followed during attendance on a given case, and this practice Dr. Herman recommended for general adoption. It was also stated that in private cases the nurse is under less discipline, but in all cases the medical attendant ought to insist on the complete obedience of the nurse to his directions.

Dr. Stuart, of Brooklyn, indorsed Dr. Herman's methods of aseptic and antiseptic procedure, and asserted that the essentials of antiseptics ought to be known both by medical attendant and nurse.

Prof. Lusk, of New York, advocated, in order to have as complete asepsis as possible, removal of all the hair from the external genitals. In regard to the employment of the douche afterward, he considered that it was not only unnecessary, but extremely harmful, as it washed away the natural secretions which prevent the germ from developing.

Dr. Smyly, of Dublin, asserted that it was not always necessary to make a vaginal examination, as by external palpation the diagnosis of presentation could be made out.

The British Laryngological, Rhinological, and Otological Association.

The Surgical Treatment of the Ethmoid Cells.—Dr. Bryson Delavan, of New York, spoke of the necessity for conservatism in nasal surgery. In some cases operative measures were absolutely required, as proved by failure of other means and by comparative results. Are extreme radical measures justifiable, and are they likely to lead to permanent objectionable disability of the parts? are questions always to be asked in these cases. Treatment should be based upon indications suggested by the anatomical and pathological conditions present. It should consist in thorough drainage of the several cavities of the sinus, persistent cleansing and disinfection of its interior, and removal of the offending tissues. The speaker described various forms of surgical treatment and presented several instruments.

Infra-Glottic Stenosis.—Dr. Sajous, of Paris, remarked that the forms of stenosis peculiar to the infra-glottic region present features especially dangerous to life and likely to be considered as manifestations of disorders in which iodide of potassium is indicated. Iodide of potassium, greatly

increasing the dangers of infra-glottic stenosis, should not be administered in a case presenting dyspnœa as a symptom, unless the non-existence of stenosis be ascertained by infra-laryngoscopical examination or the causative disease be clearly recognized as independent of the respiratory tract.

The infra-glottic space has not received the attention its importance as an inherent portion of the larynx warrants. As a consequence, the part it plays in connection with diseases of the larynx is still insufficiently appreciated, and the disorders to which it is itself liable have not as yet been clearly differentiated. All examinations of the larynx should include the infra-glottic space. The treatment of laryngeal disorders involving the glottis is more effective when the infra-glottic region is considered as part of the diseased area.

The Treatment of Chronic Laryngeal Stenoses.—PROFESSOR MASSEI, of Naples, stated that a distinction must be drawn between laryngeal stenoses proper and hypo-, or sub-, glottic stenoses; this is especially necessary from their similarity of symptoms. Again, clinically, severe cases require separation from the milder forms; clinically, on account of those cases of spasm superadded to disease. The hypoglottic tract is the most frequent seat of syphilis, tuberculosis, growths, rhinoscleroma, and also foreign bodies. Slighter laryngeal stenoses are frequently curable without local treatment, as syphilitic affections; for this sublimate injections, with or without iodine, is the best treatment. In simple inflammatory or neoplastic stenoses intubation offers the best result. Too great belief is placed in general anti-syphilitic treatment in severe stenoses, and this may be fatal. Syphilitic perichondritis yields only when general treatment is aided by surgery. Swelling in the cricoid region and ankylosis of the arytenoids do not usually improve much. Gummatous chorditis frequently requires surgical aid. If syphilitic stenoses are treated they generally require careful supervision. Tracheotomy is advisable in children suffering from stenoses caused by papillomæ, and endolaryngeal removal, and not by thyrotomy. The choice between intubation and tracheotomy is influenced by (1) the form of the stricture and (2) the cause of the stricture. In certain cases no tube can be passed through the larynx, and tracheotomy must be performed. Foreign bodies fixed in the larynx or subglottic space indicate the same treatment.

The Surgical Treatment of Laryngeal Tuberculosis.—DR. THEODORE HERYNG, of Warsaw, in discussing this subject stated that tubercle of the larynx may heal spontaneously, chiefly in cases of ulceration of the vocal cords and posterior wall; very rarely in the more serious cases, with infiltration and deep ulceration, or implicating the cartilage, or accompanied with aphonia and severe dysphagia leading to rapid disintegration. General treatment should be hygienic, dietetic, and climatic. The first and most important indication is the removal of dysphagia, and in severe cases the relief of dyspnœa. The cure of deep ulcers with inflamed and thickened bases, and surrounded by proliferation products, and certain cases of chronic laryngeal tuberculosis, is most quickly effected by surgical means. The indications for surgical treatment are: Tuberculoma of the epiglottis;

stationary tumor-like infiltrations of the posterior wall; chronic tumors with inflamed bases, resisting other treatment; partial disease of the larynx. The contra-indications are: Advanced pulmonary disease, with hectic and wasting; diffuse miliary tubercle of larynx or larynx and pharynx; cachexia; severe stenosis, due to inflammatory infiltration; nervous cases and where there is little hope of recovery. The success of surgical treatment depends on the local character of the disease, its extent, and character; on the general state of the patient, his nutrition and strength, age, etc.; on the parts of the lung affected, on the thoroughness of the operation, and on the after-treatment.

Most patients with laryngeal phthisis die of pulmonary phthisis, and a large number of temporarily-cured cases are menaced with recurrence. Proof is not wanting that in rare instances complete recovery has been obtained; again, partial cures have proved lasting; dysphagia, dysphonia, and dyspnœa can be relieved. We are now better able to treat these complications than formerly. Serious hæmorrhage is rare. Failure is often due to too late a diagnosis. The necessity for patience and perseverance by patient and doctor and of skill and knowledge by the latter was insisted on. Severe cases should be treated under special climatic conditions. That large tubercular deposits may be absorbed and that extensive laryngeal ulcers may heal, with complete restoration of voice, is proven both by clinical observations and by microscopical and anatomical observation.

Dr. Gleitsmann, of New York, said that there was no doubt that curettement of the larynx for this disease is not yet frequent in the United States, either on account of the surgeon wishing to avoid all harsh measures or on account of the acknowledged small percentage of cures. He urged the necessity for the proper selection of cases for this treatment and for further reports of all treatments. Curettement of the larynx is not supposed to cure the pulmonary disease nor to prevent relapses, but by it we improve the laryngeal lesion and thereby increase the chances of cure of the pulmonary disease. It is certainly the quickest and surest way of curing dysphagia; the chief importance of removing this symptom is on account of the improvement in nutrition sure to follow. The limitation of suitable cases is no argument against curettement, though relapses doubtless occur in proportion to the inaccessibility of the part and the difficulty of the operation.

Prof. H. Krause, of Berlin, urged surgical treatment in all cases where tubercular ulcerations are complicated with advanced infiltrations or granulations. Simple ulcerations, or those surrounded with only slight infiltration, are best treated with lactic acid. High fever and weakness form no absolute contra-indication to the operation, because even in such difficult cases relief is often obtained, and sometimes even the removal of dysphagia or difficulty of respiration. In several observed cases the laryngeal troubles disappeared entirely after operation, death being caused by the pulmonary affection. The cure of the larynx may be maintained, whilst the pulmonary process advances and causes death. Relapses happen, but, since the introduction of surgical treatment, more rarely in the larynx than in the lungs.

Surgical Treatment of Suppuration of the Accessory Cavities of the Nose.—Dr. Luc, of Paris, described an operation, first proposed by him, for the medical cure of frontal empyema. It consists, after opening widely the anterior wall of the sinus at the union of the eyebrow with the bridge of the nose, in curetting away the granulations contained in the cavity, and in destroying, by means of a chisel, the greater part of the floor of the sinus, in order to create a large communication between the sinus and the nasal fossæ. A curved probe is then introduced from the wound into the nose until it appears out of the nostril, when a large India-rubber drain is fixed to its end and drawn from below upward into the sinus, where it is deeply lodged. The wound is then sutured *per primam* and antiseptic injections performed through the drain during the following days. Four to eight days after the operation dressings may be suppressed and the local treatment continued *via nasi*. The drain may be removed after a fortnight in acute cases, and after a month in chronic cases complicated with fungosities. The method insures a diminution of the period of wound-dressing and a hardly-visible scar.

Edinburgh Obstetrical Society.

Walcher's Position in Labor.—W. E. Fothergill employed Walcher's position in six cases of delivery, five of which are described as promontory projecting, justo-minor, or a combination of these conditions (*Edinburgh Medical Journal*, July, 1895). In the sixth the pelvis was normal, but the head was very large. By allowing the legs to hang down without touching the ground, an average increase of 0.93 centimetre may be obtained in the diagonal conjugate, the *rationale* of this increase being found in the fact that the pelvic girdle can rotate about an axis passing through the two sacro-iliac joints. When the symphysis moves downward in this rotation the conjugate is increased. The weight of the legs when hanging is transmitted to the innominate bones mainly by the Y-shaped ligaments, causing the rotation described, thus sparing work on the part of the uterus and musculature generally, and avoiding pressure of the head on the symphysis. In high forceps cases Walcher's position saves the perineum from undue pressure by the forceps as well as increasing the conjugate. The strength of the operator is saved, and pressure on the head and pubic symphysis is avoided. In cases not requiring forceps, but where there is difficulty at the brim, the position saves exertion of the uterus and abdominal muscles as well as pressure on the head and symphysis. In all cases where the perineum is in danger in delivery, with or without forceps, this position, or at least extension of the legs at the hips, is of advantage in relaxing the integument and subjacent structures.

Northwest London Clinical Society.

Schott's Method in Heart Disease.—Schott does not attempt to explain the action of the gymnastic exercises nor the improvement effected by them.

H. CAMPBELL, of London, who has used the method in some of his cases, believed that the transfer of blood from the venous to the arterial system is facilitated. The exercises keep the muscles of the body in a state of gently-sustained contraction, during which the arteries are compressed and the resistance increased, thus preventing the blood flowing so readily through the muscle. The peripheral resistance is increased, consequently less blood flows into the veins, giving the latter a better oppor tunity of emptying themselves through the right heart into the arteries

GUTHRIE, in the discussion of Campbell's paper, said that in case of mitral regurgitation, in which the resistance in the arterioles was increased, there was danger that the left side of the heart might not be able to cope with it.

WILBE pointed out the danger of blood-clot or granulation forming,—a danger which Campbell did not consider as very likely to exist.—*Clinical Journal*, July 26, 1895.

RUSSIA.

MOSCOW MEDICAL SOCIETY.

Continued Bradycardia.—F. V. BOULIOUBACH describes the case of a woman, aged 67 years, very thin and feeble, who came under his care in 1891. He found the digestive and respiratory organs to be normal. The impulse of the heart was felt in the fifth intercostal space, on the mammillary line, the præcordial dullness on the right side extending beyond the left border of the sternum. There was a whistling murmur at the apex and the second left intercostal space; the cardiac contractions were 34 per minute; the pulse was hard and fairly full, the arteries sinuous and atheromatous. The liver was not hypertrophied. The urine was normal in quantity, of a specific gravity of 1014, and contained albumin and hyaline casts. The patient complained of dyspnœa, general fatigue, nausea, headache, and syncope. A year later epileptic attacks followed a moral shock, and in November, 1893, these attacks recurred several times a day. In 1894 she had acute bronchitis. In January, 1895, frequent syncope occurred, and epileptic fits at the slightest emotion, the patient feeling greatly exhausted for a few days afterward. Before the epileptic attacks there was an aura consisting of an intense burning sensation along the spine, and during the fit respiration was spasmodic, sometimes assuming the Cheyne-Stokes form. The number of cardiac contractions fell to 14, and even 8, per minute, and sometimes the heart was entirely arrested for thirty seconds. Again, the attacks would resemble catalepsy, the heart- and pulse- beats being absent for forty-two seconds; the heart-beats would then reach 140 per minute, the pulse would gain in strength and become more regular, and, if the beats reached 34 to 38 per minute, it was reasonably certain that the attack would not be repeated; if they exceeded 40, a repetition might be expected within half an hour. After this the patient

showed great weakness and somnolence, and during the access albumin appeared in the urine.

In the treatment of the case ice was applied to the præcordial region, and caffeine, codeine, and the bromides were employed. Belladonna was without effect, and, for this reason, the author believes the case to depend on a central lesion.

Odessa Medical Society.

Sudden Death during Laryngeal Treatment.—Gecheline reports two cases in which death took place suddenly during intra-laryngeal manipulation. The first patient was a young man suffering from inflammatory œdema of the glottis, possibly of erysipelatous nature. Gecheline had a number of times practiced scarification and removed the exudate, using cotton dipped in 20-per cent. solution of cocaine; but the last time he had scarcely introduced the tampon when the patient fell forward and died instantly of asphyxia.

The second patient was a young woman with a large ulceration of the glottis and growths of unknown nature on the vocal cords. She had had several attacks of suffocation, and tracheotomy had even been necessary. The author extirpated one of the vegetations, cauterizing the pedicle with lactic acid, using a liberal cocaine spray as an anæsthetic. He had scarcely finished the operation when symptoms of suffocation appeared, and the patient was placed on the table for the performance of tracheotomy, but died before it could be accomplished. Gecheline does not believe that death in either of these cases can be attributed to the cocaine, as in the first case but a minimum quantity was used ; in the second, it is true, it was more freely employed, but the symptoms caused by cocaine—vertigo, palpitation, and syncope—were not present. He attributes the fatal issue rather to spasm of the glottis, frequently observed in certain subjects at the slightest touch of the larynx, and due to irritation of the superior laryngeal nerve.

UNITED STATES.

American Laryngological Association.

Tuberculosis of the Upper Air-Passages.—Dr. Jonathan Wright opened the discussion of this subject by a consideration of the etiology. (*Medical Record*, July 20, 1895.) Recent bacteriological progress has led us to modify very largely the literal interpretation of Koch's postulates regarding the relations of germs to disease. We now know that bacteria can get through epithelium and in some instances they seem to be destroyed by phagocytosis. It is believed possible that the lymphoid tissue at the base of the tongue may become inoculated by tubercular material taken in as food. It is conjectural, however, as to whether the bacilli found here are really in the tissues or in the superficial papillæ. We can inject tuberculous material into animals and kill them, but the Pravaz syringe does not exactly meet the requirements of clinical medicine. We all get a dosage of

tubercle bacilli sooner or later, and one in every seven falls. Autopsies reveal, in one out of every two or three, evidences of arrested tuberculosis. The mortality is due not so much to the bacillus as to the bad general environment under which men live. Physicians, as a class, are not particularly liable to tubercular disease, though exposed most constantly thereto. Children fed on the milk of Alderney cows suffer especially.

The scanty anastomosis between the external and internal lymphatics about the neck explains perhaps why so many escape, but in the nose the abundant communication of the lymph-channels with those of the subarachnoid space may account for the frequency in children of tubercular meningitis. The protection of the larynx is also very remarkable. We have abandoned Louis's theory of corrosive sputa, but many patients are either not examined or the tubercular deposit escapes observation, or the tubercular ulcers are seen only when the patient is *in extremis*. Out of twenty-five cases examined, Dr. Wright found nasal or throat tuberculosis in only four. As we clinically see the disease, the pyogenic cocci may first make a breech in the epithelium, through which the bacillus enters. The latter cannot produce an abscess. It is doubtful whether it can penetrate glandular epithelium or not.

Sections of the laryngeal mucosa of newborn children show that it has a wavy outline, especially in the interarytenoid space. Under vocal strain this wavy columnar epithelium stretches, and so exercises a protective influence over the deeper laryngeal structures. Nasal tuberculosis in phthisis generally comes toward the end of the disease, as does that of the pharynx, though the latter is possible in the earlier stages of acute miliary tuberculosis.

Dr. C. C. Rice, of New York, presented a paper on the diagnosis of the disease. Tuberculosis may occur either as an ulceration on the nasal septum and floor, and resembling tubercular ulcerations in general, or as small papillary growths attached to the turbinated tissues. Nasal tuberculosis is frequently overlooked, since it may co-exist with septal specific disease, and because the small growths frequently removed are not examined. In any case of chronic ulceration in a patient with pulmonary disease, we should be suspicious if the nasal condition resists the effect of the iodide. Tuberculosis of the fauces is usually associated with an acute general tuberculosis rather than the customary chronic lung process. Occasionally miliary nodules may appear in the soft palate before it undergoes ulceration, but probably all organs are affected at the same time.

Eighty per cent. of all cases of laryngeal phthisis can be easily diagnosed, but great care needs to be exercised in the remaining 20 per cent. Of this latter proportion, perhaps one-half cannot be definitely diagnosed without the aid of the iodide and the microscope. In ordinary cases nothing can be more typical than the semi-œdematous, semi-inflammatory swelling of the tubercular infiltrations, and the superficial "moth-eaten" ulcer which follows, with its gray surface. Such lesions are usually symmetrical and upon a very anæmic surface. In the laryngeal appearances in incipient tuberculosis we find localized anæmias of the hard and soft palate in an

otherwise healthy pharynx, and, with this, enlarged capillaries merging from the different portions of the palate toward the uvula. In addition, we have elevation of the papillary layer in the interarytenoid commissure and feeble action of the internal laryngeal adductors. Recurring papilloma on the vocal band is to be regarded as a suspicious circumstance, as there is often an intimate relation between them and tubercular laryngitis. Localized congestion of the arytenoid cartilages is also suspicious.

Dr. E. L. Shurly, of Detroit, expressed the belief that there may be a phthisis without tuberculosis, and doubted whether the post-mortem table reveals evidences of previous bacillary invasion as often as is claimed. The best local remedies in his hands have been chlorine gas, solutions of sodium formate, and iodoform. As a specific internal, plain iodine with chloride of gold and sodium have accomplished good results. He would pay great attention to diet, and in painful swallowing would use gavage. Vegetable food should be combined with the meat extracts in these cases. In the laryngeal cases alcohol was apt to be too irritating. We should not take away all hope from our patients, and when they get so low we should use morphine enough to keep them comfortable. Tracheotomy, scarifying, and curetting he did not believe in.

Dr. J. W. Gleitsmann discussed the surgical treatment, saying that curettement was steadily gaining in favor. In his opinion it should be regarded as analogous to excision by the surgeon of a tuberculous joint. It removes a diseased area, a focus of infection which is a constant drain upon an already debilitated system. It is, in properly-selected cases, more effective, quicker, and better in result than any other procedure. Besides, the infiltration of the arytenoid region, which is the great cause of dysphagia, can often be removed at one sitting by the double curette. Healing is prompt and cicatrization rapid. Moreover, the suffering of patients due to abundant nerve-proliferation justifies arytenoidectomy. Even in active pulmonary disease with hectic, diminution of dysphagia means more nourishment taken and a consequent improvement in the general condition. Additional advantages gained are improvement in voice, cough, and respiration. The indications are: 1. Primary tubercular disease without lung complication. 2. Cases with concomitant lung disease, either incipient or which has stopped short of softening or hectic. 3. Especially circumscribed ulcerations and infiltrations. 4. Dense hard swelling of the arytenoid region, ventricular band, posterior wall, tuberculous tumors, and affections of the epiglottis. 5. Advanced lung disease with distressing dysphagia from arytenoid infiltration. The contra-indications are: 1. Advanced pulmonary disease and hectic fever. 2. Disseminated tubercular disease of the larynx, leaving little or no area of healthy tissue. 3. Extensive infiltration producing stenosis. Here tracheotomy is indicated.

Heryng's single curettes are best suited for cleaning and scraping of ulcerations, and Krause's double curettes and Heryng's rotary curettes for excision of tubercular infiltration. Subglottic lesions can be operated upon with Scheinmann's forceps, and an attempt may be made to reach the ventricles of the larynx with laterally-bent forceps. Absolute quiet is neces-

sary after operation, and until cicatrization is complete daily applications should be made of lactic acid and pyoktanin (1 or 2 per cent.). Cicatrization occurs in from seven to twenty-eight days. Ulcerations which are well defined do better than if shallow and extended. Dense infiltrations (which are generally localized) do better than œdematous conditions.

Dr. T. Morris Murray, of Washington, D. C., had used lactic acid in seven or eight cases of laryngeal and pharyngeal ulcers and had seen good results in three. One case was curetted two weeks before the patient's death. The uvula was also infiltrated in this case. The ulcer had healed and the patient's last days had been rendered much more comfortable. One case had remained healed now for five years.

Dr. Ingals, of Chicago, thought that of one thousand cases operated on and one thousand cases treated topically, the latter series would show more cures than the former. He had had four recoveries from laryngeal and pharyngeal ulcerations by simply rubbing in lactic acid without previous scraping. In the deeper cases we should curette, as it was of doubtful propriety to cut away large masses of tissue. The trichloride of iodine (gr. i to ij to water ℥j) had served him well. He did not like to use cocaine, on account of its depressing effects upon the nervous system. His favorite mixture is one of carbolic and tannic acids with morphine. It smarts at first, but there is no pain afterward.

Dr. Daly had seen some laryngeal cases recover under diet, inhalations, and especially iodoform, with which he saturates the patient. He has never curetted, thinking it useless.

Dr. Wright, in closing the discussion, said that he was very skeptical as to the treatment of laryngeal tuberculosis. Ulcers will occasionally heal under curettement and lactic acid. We have been looking too much at one single etiological factor, whereas there are many. Laryngeal tuberculosis may give no symptom whatever, even when the erosive process has invaded the cartilage. The cases reported cured have been limited to the first stage of the disease. Very few cases are suitable for Krause's and Heryng's methods.

Dr. Shurly had tried Dr. Ingals's sedative formula, but had great difficulty in making a good mixture of the three ingredients, and used them separately. As to creasote, he felt disappointed in it, but thought it a good, mild disinfecting agent. He had had no experience with the curette. It seemed absurd to expect recovery by scraping a few ulcers while there were ulcerated patches on invisible areas.

American Pediatric Society, Hot Springs.

Tapping the Vertebral Canal.—This method was first recommended by Quincke in 1891 as a means of distinguishing between serous, purulent, and tubercular meningitis. The operation is done with the understanding that there is an open communication between the subarachnoid space surrounding the spinal cord and the ventricles of the brain. The terminal cone of the cord is situated at the level of the first lumbar vertebra, and if

a puncture is made below this point it is not likely that any of the divergent strands of the cauda equina will be injured. The patient's body should be bent forward while the puncture is being made. In semicomatose children and in adults narcosis is not required, and aspiration is also unnecessary, as the cerebro-spinal fluid will ooze out drop by drop or spurt out if it is under much pressure.

AUGUSTUS CAILLÉ, of New York (*New York Medical Journal*, June 30, 1895), has had a personal experience with tapping the spinal canal in four cases, and gives the following description of his method of procedure:—

"After locating the third and fourth lumbar vertebræ I place the middle finger of my left hand upon the spinous process of the third and the index finger on the spinous process of the fourth lumbar vertebra, pressing firmly upon the bone. I now mark with the nail of my right index finger the interspace between the two fixed points and puncture precisely in the median line with a large-sized hypodermatic needle attached to its syringe, which is entirely used as a handle and not for the purpose of aspirating. No undue force should be used in propelling the needle forward; it readily enters the spinal canal and can be moved about freely if it is in the right place. The syringe may now be unscrewed from the needle, which remains *in situ* and permits the fluid to escape into a sterilized bottle for subsequent examination." He expresses the opinion that tapping of the spine may be safely employed to relieve pressure symptoms in various forms of disease. In chronic hydrocephalus it is a safer procedure than tapping the cranium. For diagnostic purposes its value is firmly established.

Diphtheria and Antitoxin.—The discussion on this subject was based on clinical experience, and according to the *Archives of Pediatrics* (July) it was conservative and judicious According to F. GORDON MORRILL, of Boston, the immunizing effects of antitoxin, when fresh, can be relied upon in anything resembling clinical diphtheria for thirteen days, and probably for a longer space of time. In no instance in his experience was the bacillus detected in a shorter time in the nose or throat of any child who began with a clear record. This point, if eventually established, is of practical importance as showing that an immunized child is not only safe as concerns diphtheria, but is also safe as concerns others for a definite length of time.

AUGUSTUS CAILLÉ, of New York, reported 41 cases treated by antitoxin, 34 of which completely recovered. He observed no untoward effects.

L. EMMETT HOLT, of New York, from its use for immunization during epidemics of diphtheria in two institutions, expressed a conviction that it was of inestimable value for immunizing purposes.

A. SEIBERT, of New York, reported 28 cases treated with the remedy, 26 rapidly recovering. He immunized 36 children, all remaining well.

J. H. FRUITNIGHT expressed the belief that the usefulness of antitoxin would be limited to cases seen early and to immunization of those exposed to infection. In the later periods of the disease he is inclined to rely upon the older methods of treatment by bichloride of mercury, calomel fumigations, iron, and stimulants.

JOSEPH E. WINTERS, of New York, defended his position as an opponent of the method, believing that the apparent diminished mortality was due to the fact that numerous light cases were included in the statistics, as had not been done before. The prevailing opinion of the society, however, was strongly in favor of the treatment, though there was no tendency to draw decided conclusions until more evidence is available. The following resolution was adopted: "That, in the opinion of this Society, the evidence thus far produced, regarding the effects of the antitoxin of diphtheria, justifies its further and extensive trial."

Selections from Reports of Members of the Annual's Staff of Correspondents.

Holland.

DR. A. MIJNLIEFF,
REDACTEUR CORRESPONDENT FÜR GEBURTSHÜLFE UND PUERPERAL KRANKHEITEN.

Alle Bücher, Thesen, Separat ab drücke, etc., über obengenannte Gegenstände in hollandische Sprache erscheinend, solten Herrn

DR. MIJNLIEFF,
Breukelen,
Holland.
zugesandt werden.

Local Treatment of Puerperal Endometritis.—TEN BOKKEL HUININK describes the method employed at Van der Meij's clinic, in treating this disease. (*Nederlandsch Tydsch. v. Verlos. und Gyn.*, Jahr. 5, No. 3.) As soon as fever appears, which can be attributed to no other cause than possible infection by the genital apparatus, a careful inspection of the vulva and vagina is made, and ulcerations resulting from puerperal lesions carefully disinfected with sublimate and treated with tincture of iodine applications. If the temperature does not fall after this treatment, tincture of iodine is applied to the uterine cavity and cervical canal, after careful disinfection with a sublimate or carbolic-acid solution. If this treatment is not instituted too late, it will arrest the development of the disease, as proven by fifty-two cases at the clinic, described by the author.

Galactorrhœa.—C. VAN TUSSENBROEK describes a case of galactorrhœa in a primipara (*Nederlandsch Tydsch. v. Verlos. und Gyn.*, Jahr. 5, No. 3) after miscarriage. All therapeutic measures proved unavailing, and after five months had elapsed, and the patient had become greatly emaciated, he decided to remove the nipple. Recovery soon followed. From histological examination the author concludes that the affection is only an exaggeration of the normal secretion of milk, neither the secreting epithelium nor the secretion itself showing any pathological changes.

Uterine Rupture during Labor.—T. D. DOORMAN reports a third case, in addition to two previously reported, in which he was able to diagnose rupture of the uterus, although the clinical signs were absent. The child passed into the abdomen, and, the head remaining engaged, he used the forceps to extract the fœtus. H. A. Diepen (Inaug. Thesis, Amsterdam) describes five cases, in two of which the rupture occurred twice in the same

patient, recovery taking place in both. Two of the five cases ended fatally. According to this author the treatment should be chiefly prophylactic. If the case be one of transverse presentation, contracted pelvis, or hydrocephalus, and labor has set in, version, internal or external, should be performed, the vicious presentation corrected, and abdominal pressure stimulated. In hydrocephalus, puncture with the trocar may be performed, followed by perforation and cranioclasis if the head does not descend. If rupture is threatened and the child is living, the forceps may be carefully applied, provided the cervix is sufficiently dilated and the head already engaged in too small a segment. In a neglected transverse position version should not be tried, but the volume of the fœtus should be diminished, either by decapitation with Braun's hook or by embryotomy. The author prefers to begin with thoracotomy and terminate with decapitation, in order not to expose the uterine segment to too great tension by the necessary introduction of the hand. Cæsarian section is indicated only when the signs calling for it are absolute.

If rupture has occurred and the fœtus is still in the uterus, recourse should be had to the forceps or to perforation with cranioclasis, and, if there be a transverse presentation, to embryotomy. Decapitation and version should be avoided. If the child is partly or entirely outside of the uterus, delivery should be effected through the wound, and when the placenta has been removed the uterus and the wound should be carefully tamponed with iodoform gauze. Laparotomy is indicated when the woman's life is in danger from internal hæmorrhage which cannot be checked by tampons, and in cases where the child cannot be extracted on account of dystocia. In cases in which the operation is necessary, it should be followed by amputation of the uterus. Experience does not prove that the size of the uterine wound is increased by the extraction of the child by the natural passages, or that there is great danger of hæmorrhage.

Sweden.

DR. F. EKLUND,
Brefvexlande Medarbetare
för den
SVENSK MEDICINSK
LITTERATUR.

Af alla i Sverge utkommande medicinska tidskrifter, bocker, afhandligar, monographier a. s. v. torde ett exemplar benåget öfversändas till

DR. ABRAHAM
FREDRIK EKLUND,
Sibyllegatan, 3 A,
Stockholm.

Puerperal Convulsions.—CHARLES WETTERGREN (*Eira*, vol. xix, No. 8) had under his care a farmer's wife, aged 35 years, who, six hours after the delivery of her sixth child, was seized with violent convulsions, followed by intervals of profound sleep, and, later, by coma and stertorous breathing. The pupils did not react; the urine was dark, scanty, and contained a large quantity of albumin. A subcutaneous injection of sterilized salt solution was given, and artificial respiration kept up in order to prevent pulmonary œdema. When consciousness returned the patient was given three 0.20-gramme (3-grain) doses of calomel with 0.10 gramme (1¾ minims) of digitalis solution. An aperient clyster proved effective and was followed by a bath at 35° to 41° C. (95° to 105.8° F.) for

one-half hour and a clyster of chloral. She was then wrapped in blankets and kept in a state of copious perspiration for four hours, plenty of milk being given. The eclamptic attacks did not return, but on the fifth day she suffered from acute hallucinations and excitement, and an exanthem appeared on the trunk and hands. There was slight fever and involuntary movement of bladder and bowels. Quinine and ergotine were given and chloral and iodide of potassium at night. Recovery eventually took place.

Placenta Prævia.—The same author describes a case of placenta prævia with continued and violent hæmorrhage, the patient being brought to hospital in collapse after a ride of eighteen miles. Transfusion of a salt solution was employed and the still-born fœtus extracted by version. Gauze tampons soaked in lysol were applied, and recovery soon followed, though complicated by endometritis.

Puerperal Mania.—WETTERGREN also gives the details of another case, that of a woman 20 years old, a multipara, with no hereditary psychical history, but whose nervous system had been affected by numerous labors and by profuse and constant uterine hæmorrhage. There was also chronic inflammation of the uterus and left Fallopian tube. During pregnancy the patient suffered from marked melancholia, and after labor from acute mania. She was admitted into hospital in a state of great exaltation. After the uterine mucous membrane had been curetted her condition changed to great depression, and in a few days erotomania appeared, again changing into a stage of furious excitement, and from this condition into nymphomania, which, six months later, at the time of report, showed no signs of amelioration.

Inguinal Hernia.—G. EKEHORN (*Hygiea*, vol. lvii, No. 4) states that the weak point of Bassini's operation is the cutting of the oblique externus muscle, which may lead to gangrene, especially of the middle portion, and which may become disseminated through the medium of the silk suture; and, even should the wound heal, the spot at which the aponeurosis has been cut remains weak. Ekehorn, therefore, omits this detail of the operation, together with the row of sutures which it necessitates, and connects Poupart's ligament with the lower border of the deeper abdominal muscles by a single pair of deep sutures,—a procedure somewhat more difficult than Bassini's, but equally effective.

Clinical Notes.

Cyanosis.—According to H. RICHARDIÈRE (*L'Union Méd.*, July 20, 1895), cyanosis, even in typical cases, is subject to considerable variation, the violet color of the skin and mucous membranes, more or less pronounced in the ordinary condition of the patient, becoming temporarily exaggerated during effort or emotion, or during intercurrent diseases of the respiratory passages. In certain instances veritable crises seem to supervene without appreciable cause, lasting from several hours to several days, the skin be-

coming livid. Dyspnœa, always present in such cases, follows the variations of the cyanosis. In a patient observed by him at the Hospital Hérold, Paris, and previously described by VARIOT and CHABRY (*Jour. de Clin. et Thér. Infantile*, p. 1056, 1894), this variability exists in a marked degree. The mere addressing of the boy causes the cyanotic color of the face to increase, and he becomes blue at the slightest emotion.

This variability of symptoms, especially in cases of cyanosis with non-occlusion of the duct of Botal, seems, *a priori*, paradoxical; a congenital and definite lesion should apparently cause definite and fixed clinical symptoms. Observation shows that this is, however, far from being the case. In congenital affections of the heart cyanosis frequently does not appear until some time after birth. In some cases it develops suddenly after a violent effort or a disease of the respiratory tract. CHATIN and BRET (*Province Méd.*, May, 1895) confirm the existence of this late form, and PIERRE MARIE (*Bull. Méd.*, January 13, 1895) describes a case in which the disease declared itself at the age of about 30 years. The patient had suffered from dyspnœa from infancy. A similar case is described by Richardière, in which the cyanosis followed severe bronchitis at the age of 30. At the autopsy the duct of Botal was found to be permeable.

The condition of the blood in the cyanosis of congenital heart disease is of interest. In Marie's case there were from 7,500,000 to 8,000,000 globules per cubic millimetre instead of 5,250,000, the normal number, and 0.60 per cent. of iron instead of 0.44 per cent. This increase the author attributes to difficult hæmatosis, through the mingling of arterial and venous blood, and especially through stricture of the pulmonary artery, so frequent in these cases. HAYEM expresses the same opinion, apropos of a patient seen by him, suffering from congenital cyanosis with transposition of the viscera. (*Méd. Moderne*, June 22, 1895.) The latter author opposes the view of VAQUEZ (*Bull. Méd.*, January 20, March 6, 1895), that the increase of blood-cells is due to increased activity of the hæmatopoietic system, and that the color of the skin depends upon the excessive number of globules. Variot, however, is a partisan of this view, the skin owing its blue color to the lack of oxygen in the blood.

G. A. GIBSON, of Edinburgh (*Lancet*, January 5, 1895), examined the blood in a case under his care, a boy 8 years old, and found that the amount of hæmoglobin was 110 per cent., and the number of the hæmocytes and leucocytes, respectively, 8,470,000 and 12,000 per cubic millimetre. In another patient, a boy aged 2 years and 4 months, suffering from congenital heart disease, the hæmoglobin was 92 per cent., the red corpuscles numbered 6,700,000 and the white corpuscles 12,000 per cubic millimetre. CARMICHAEL (*Edinburgh Hosp. Rep.*, vol. ii, 1894) had a patient with 8,100,000 red corpuscles and 16,000 white corpuscles per cubic millimetre. The theory favored by Gibson as accounting for the presence of so great an increase is that, the functions of the corpuscles being lessened, their wear and tear is not so great and their individual duration is increased. The number of the corpuscles must in this way be proportionately augmented, and this must lead to the numerical increase, as well as to the high percent-

age of hæmoglobin, until a balance is struck between the production and destruction of the blood-corpuscles. As regards the prognosis in these cases, JULES SIMON (*Presse Médicale*, March 30, 1895) states that, when due care is exercised, patients with congenital cyanosis may live to the age of from 13 to 22 years, while some have been known to reach the age of 50 or 60 years. Exertion must be avoided, and arsenic and phosphate of lime used as tonics, with digitalis, for ten days every month.

Abscess of the Liver following Dysentery.—JAMES JAMIESON observed a case of abscess of the liver following dysentery, in which the diagnosis was obscure. (*Australian Medical Journal*, May 20, 1895.) Post-mortem examination showed the presence of a very large abscess-cavity on the upper surface of the right lobe of the liver, which had been tapped, and which, it was estimated, must have contained not less than 16 ounces (500 cubic centimetres) of pus. When the liver was turned over for the purpose of extraction, another abscess in the left lobe burst on the under surface, discharging about 6 or 8 ounces (186 to 248 cubic centimetres) of yellow, creamy pus; and further examination revealed a third abscess, more deeply seated between these two. There were extensive signs of peritonitis on both upper and under surfaces of the liver, but no generalized peritonitis. The descending colon had its wall somewhat thickened, but showed no ulceration; but the cæcum showed a very large number of ulcers, the small intestine not being in any way affected. Though the condition was evidently of some standing, there was not much to direct attention to the liver as the seat of serious trouble till quite a late stage. The pain in the chest at the time of admission to hospital was at the upper part, and the mark of a blister showed that it had also been there at an earlier period. With dysentery of some standing, pain in the right side, displacement of the lung upward, and fever, there might have been clearer suspicion of liver-abscess, if the pain had not at first been situated so high up, and if fever had not gone down so rapidly, and many of the symptoms had not undergone such marked improvement after the first three or four days.

Suppurative Pylephlebitis following Hydatid Cyst.—A. A. LENDON, of Adelaide (*Australasian Medical Gazette*, May 15, 1895), describes a fatal case of suppurative pylephlebitis secondary to suppuration in the fibrous sac of an echinococcous cyst of the liver. The sequence of events in this case probably was as follows: An hydatid developed in the right lobe of the liver, and in the course of its growth the adventitious sac became adherent to or incorporated with the gall-bladder, a large branch of the portal vein, and the lesser omentum. Rupture of the mother-cyst occurred, and either before or after this event bile escaped into the cavity of the fibrous sac. Next, suppuration took place and sloughing of portions of the fibrous sac ensued; so that in one situation perforation was threatening, and in another it actually caused death. The suppuration further set up adhesive phlebitis and thrombosis of this large branch of the portal vein; ulceration or sloughing of the sac then caused perforation of its coats, and the thrombus liquefied into pus, which penetrated to its peripheral branches.

Suppurative pylephlebitis, or portal pyæmia, is a rare disease, and almost

always a consecutive lesion. As a consequence of suppuration within the liver, it is said to be much rarer than suppuration within the branches of the hepatic veins, which usually leads to general pyæmia. As a complication of suppurating hydatids of the liver, it is still more rare, the author not being able to find the record of such a case.

Addison's Disease in Tuberculosis.—GIOFFREDI and ZINNO describe the case of a young woman who, in an advanced stage of pulmonary tuberculosis, experienced a severe moral shock (*Progresso Med.*, No. 5, 1895). A week later typical Addison's disease appeared, with melanodermia, pigmented spots on the mucous membrane, and asthenia, death soon following. At the autopsy a large cavity was found in the lung, the suprarenal capsules were increased in size and caseous, while the great sympathetic, the pericapsular ganglia, and the cœliac plexus were not involved. As is known, there are two theories as to the causation of Addison's disease,—one an alteration of the capsule itself and the other a lesion of the great sympathetic (Semmola); while Zuco and Albanesi claim that one of the functions of the suprarenal capsules is to destroy a substance the product of cellular disassimilation, viz., neurine. The authors reconcile these theories by stating that, where a capsular lesion occurs, as in their own case, the disease is due to arrest of function of the capsules (as the non-destruction of neurine); in cases, on the other hand, in which the capsules are free and the nerves involved, the result is the same, but due to disturbance in the innervation of the organ.

Retroperitoneal Treatment of the Pedicle in Hysterectomy.—FAGUET and VITRAC publish nine interesting cases from the service of Lannelongue at the hospital St. André, Bordeaux, with eight recoveries (*Revue de Chir.*, June, 1895). Supra-vaginal abdominal hysterectomy was done for fibromyoma, the pedicle being treated retroperitoneally. Lannelongue always removes the uterus with the appendages, leaving the neck adherent to the vagina. By his method the stump formed by the neck is protected in the abdominal cavity by suture of two seromuscular flaps, one taken from the anterior, the other from the posterior surface of the uterus. The mucous membrane of the cervical cavity is destroyed by the thermo-cautery. The authors express the opinion that retroperitoneal treatment of the pedicle for uterine fibromyoma is superior to all other methods, rendering abdominal hysterectomy as benign as any other abdominal operation.

Scarlatina as a Cause of Rheumatism.—With the exception of blennorrhagia, which has been pointed out as playing a possible etiological rôle, the infectious diseases have not as yet been held responsible for certain cases of chronic progressive polyarthritis. DAUBAN (*Thèse de Paris*, 1895), however, shows that such may be the case and quotes an instance observed by Péron in which scarlatina, followed by scarlatinal nephritis, was the immediate cause of chronic and well-marked progressive rheumatism. Scarlatina had occurred at the age of 12 years, and when seen, at the age of 23 years, the patient presented numerous deformities, principally of the upper extremities. These were not exactly the same as seen in true nodular

rheumatism, as they involved the synoviæ and the fibrous tissue about them, instead of the bones themselves.

General Infection in Broncho-pneumonia.—Pochon (*La Méd. Infantile*) observed a case of broncho-pneumonia in a girl of 2½ years, of somewhat delicate appearance. The course of the disease was severe, and after about fifteen days the limitation of the murmurs to the apex of the lungs led the author to fear a possible tuberculosis, when the appearance of a new phenomenon showed the case to be one of generalized infection, due to the pneumococcus. Without any previous symptoms calling attention to the abdomen, an immense quantity of greenish-yellow, inodorous pus issued from the umbilicus, pressure over the loins increasing the flow. This suppurative peritonitis had been insidious in character, the temperature not having gone beyond 37.5° C. (99.5° F.) for several days, and not rising at the moment of evacuation. The pus contained the pure encapsulated pneumococcus of Talamon-Frænkel, killing mice in twenty-four hours after inoculation under the skin. Pus issued from the umbilicus several times, and always without fever; on the contrary, the temperature fell below normal, descending progressively until, four days after the first evacuation, it reached 35.4° C. (95.8° F.) in the rectum. Six days later a purulent discharge from the vagina occurred, continuous, but greatest in the morning. It gradually diminished, and at the end of a month had ceased. The pus was identical with that from the umbilicus, the vaginal discharge being, therefore, but a second spontaneous opening of the purulent peritonitis. During this time the child was apyretic, except for several days, when her condition was complicated by an attack of varicella. She then rapidly regained her strength, when suddenly pain in the ears supervened, followed by a purulent discharge which soon became fetid, and which was found to contain the pneumococcus in a virulent state, associated, however, with the bacillus pyogenes fœtidus. The saliva was also found to contain the pneumococcus, but the blood was always sterile. At the time of report the child appeared to be in good health, a slight vulvo-vaginitis only persisting, in which the pneumococcus could still be found, together with ordinary microbes.

A Physical Sign of Adherent Pericardium.—Walter Broadbent publishes (*Lancet*, July 27, 1895) the notes of four cases at the Brompton Hospital for Consumption, in each of which there is visible retraction, synchronous with the cardiac systole, of the left back in the region of the eleventh and twelfth ribs, and in three of which there is also systolic retraction of less degree in the same region of the right back. In all the cases there is a definite history of pericarditis, and in three of them there are other conditions strongly suggesting an adherent pericardium. The only means of causing this retraction on both sides seems to be the diaphragm, which, if pulled upon, would have more effect on the floating eleventh and twelfth ribs than on the other, more fixed, ones. In cases of large heart with adherent pericardium there is a considerale area of the ventricles closely adherent to the central tendon of the diaphragm, and the powerful contraction of the hypertrophied heart must give a decided tug to this structure. That it should affect the ribs more often on the left side

would be expected from the adhesion being mainly to the left of the middle line; the liver, also, which is often large in these cases, may restrain the movement on the right. Of these cases the first is one of aortic disease of rheumatic origin, and the others of mitral regurgitation, with a varying amount of stenosis. In cases 1, 2, and 4 there is evidence of adhesion of the pericardium to the chest-wall as well, but in case 3 the heart moves freely under the ribs and the lung expands well over it; so that the sign is much more important, as being the only clear evidence that the pericardium is adherent. This sign has long been pointed out by Sir William Broadbent in the wards of St. Mary's Hospital, but, so far as the author knows, has not had sufficient importance attached to it elsewhere. Adherent pericardium has frequently such a serious influence on the course of valvular disease that any aid toward the diagnosis of the condition seems worthy of attention.

Diagnosis of Lingual Hemiatrophy.—P. Londe (*Ann. de Méd.*, July 11, 1895) observed, at the clinic of Brissaud, a case of right lingual hemiatrophy due to traumatic neuritis. The atrophy was accompanied by reactions of degeneration, and the author found that there was a neuritis of the hypoglossal nerve on the same side, due to severe pressure from a bony lesion at the foramen of the condyle. The diagnosis was obscured by the fact that the left facial seemed to be involved, there being deafness and alteration of electrical excitability on that side. The hemiatrophy simulated hemispasm, but was distinguished from the latter by a marked puckering of the left half of the mucous membrane, in relation to the diminution of the subjacent muscle. Further, in comparing the characteristics of the case with those of a case of hysterical hemispasm in the service of A. Robin, it was found that there was no puckering of the mucous membrane in the latter; that the tongue, instead of being spread out as in the case of atrophy, was drawn to a point and seemed heaped up, as it were; while the spasmodic character of the deviation was revealed by the inflexion of the lingual muscle. On the other hand, the deviation, which might be called paralytic, in the case of atrophy was due to the unilateral impulsion causing the projection of the tongue; and when the latter organ was returned to the mouth all deviation and stiffness disappeared, only the puckering on the right side remaining. These points enabled the author to make a differential diagnosis between the two conditions.

The Urine in Variola.—Auché and Jonchères, of Bordeaux, (*Revue de Médecine*, June, 1895) find that the quantity of urine in discrete small-pox varies in different patients, from 600 to 1400 cubic centimetres (19 to 45 fluid-ounces) in the stage of suppuration to from 800 to 2000 or even 2600 cubic centimetres (25½ to 64 or even 83 fluidounces) in the period of defervescence. The urinary curve is much more regular; relatively high at the period of eruption, it falls at the stage of suppuration and becomes elevated at the moment of defervescence. In some patients there is a true urinary crisis. The toxicity of the urine in small-pox is about normal at the stage of eruption, diminishes, sometimes considerably, during the fever of suppuration, increases markedly during defervescence, and returns to normal in one, two,

or three days. Frequently there is a veritable unloading of the urotoxic material, corresponding almost exactly to the urinary crisis. In cases in which febrile complications occur during convalescence the toxicity of the urine diminishes at first and increases again when the fever falls. The delirium of the acute period of variola is apparently a toxic delirium, and in one case the authors observed that its variations were exactly the same as those of the urinary toxicity. In hæmorrhagic variola the curve and toxicity of the urine fall at the onset and remain lowered until death occurs.

Percussion of the Stomach.—FEDERN describes an hitherto unnoticed phenomenon of percussion of the stomach. If the normal stomach of an individual in the dorsal decubitus be percussed, a tympanitic sound will be produced. After several deep inspirations this sound becomes clearer and more distinctly tympanitic. The modification in the sound can only be explained by an increased quantity of air in the stomach following the inspirations. It has for some time been admitted that air was found in the stomach, but it has been supposed to be introduced during deglutition. If it be true that it is introduced during respiration, the fact cannot be without influence on the digestive functions, and should be more closely studied.

Anal Fissure or Ulcer.—HARRISON CRIPPS, of St. Bartholomew's Hospital, London (*Brit. Med. Journ.*, July 20, 1895), states that if a case of this kind is of comparatively recent origin, if muscular fibres are not exposed, and there is no undermined muco-cutaneous surface or sinus present, there is a fair chance of a cure being effected by simple remedies. The motions must be kept soft by a laxative; a teaspoonful of the confection of senna early every morning is effective. Capsules of 15 to 30 drops of the fluid extract of cascara sagrada may be taken at bed-time, or the following dinner pill: Pil. col. co., 10 grains (0.65 gramme); pil. rhei. co., 20 grains (1.3 grammes); mix and divide into six pills, one to be taken at dinner-time. The anus should be gently washed with soap and water night and morning, and on no account should paper be used in the closet, the part being cleaned with a sponge or cotton-wool and water. Two ointments may be prescribed: the one a soothing ointment to be applied five minutes before the motion is passed, the other an astringent ointment to be used at night. It is better for the patient to apply this with his finger than by any form of ointment introducer, for the ulcer is just at the orifice, and if the patient strain down it can be effectually applied. Six grains (0.39 gramme) of morphine to 1 ounce (31 grammes) of unguentum petrolii form a good soothing ointment; for an astringent ointment subsulphate of iron, 10 grains (0.65 gramme) to 1 ounce (31 grammes) may be used, or tannic acid in the proportion of 20 grains (1.3 grammes) to the ounce (31 grammes). Another ointment he has seen occasionally effectual is composed of 15 drops of carbolic acid and 10 grains (0.65 gramme) of powdered camphor to 1 ounce (31 grammes) of simple ointment of unguentum petrolii.

Operative.—Palliative treatment may have failed, or the case from the first may be one better treated by operation. If the ulcer is of old standing and the muscular fibres exposed, or if the edges be undermined or a sinus present, palliative treatment is mere waste of time, for by an operation

properly performed the patient may be cured. It should be done as follows: At bed-time two days preceding that of operation the patient should take two pills (pil. col. co., gr. iv; pil. rhei. co., gr. vj; mix and divide into two pills); this will insure the bowels being well opened the day before the operation. On the morning of the operation, and an hour before its performance, the bowels should be washed out by an injection of a pint of hot water. The patient being under ether in the lithotomy position, the sphincter is gently dilated. The ulcer is now thoroughly examined with a fine probe to see if any fistulous tract exist, and the extent to which the edges may be undermined. If a sinus exist it must be laid open; if there is no sinus, or if present after it has been divided, a speculum is introduced into the rectum. The surface of the ulcer is then divided in the middle by a clean cut. The incision should commence on the mucous membrane half an inch above the ulcer and end on the skin half an inch or a little more below it. The depth should be such as partly to divide the external sphincter, and to accomplish this it would have to be at least a third of an inch in depth in the middle. It is quite true that in many cases a more superficial incision will suffice, but, as superficial incisions are often insufficient, it is better to make a bolder one at once. Moreover, the depth of the wound makes little difference in the time taken in its healing. After the incision has been made a narrow strip should be cut with a pair of scissors off the two edges, which will otherwise overlap and interfere with the healing. A strip of lint smeared with eucalyptus-ointment, laid in the cut, and covered with a pad of aseptic cotton-wool, completes the operation. For a fortnight the patient should be kept in a recumbent position, and, as in all other rectal operations, the wound should be thoroughly washed and redressed night and morning. A dose of castor-oil is given to open the bowels on the fifth day, and after this a mild laxative every alternate evening. When the patient is allowed to get up, it will do him no harm to walk about a bit, but he should sit as little as possible till the wound is completely healed. Nothing retards the healing of a rectal wound so much as the congestion produced by long sitting.

Recent Suggestions in Therapeutics.

Administration of Santonin.—COMBEMALE, of Lille (*Bull. Méd. du Nord*, July 12), from his personal experiments in acute poisoning by *santonin*, concludes that the moment the drug appears in the urine it becomes dangerous. When within two hours after a dose of *santonin* the urine takes a red color on the addition of *potassium solution*, the danger is imminent. This test can be employed to detect a slight degree of intoxication by the drug and prevent chronic or subacute poisoning. If the *santonin* be followed by a purgative to evacuate the ascarides for which the vermifuge is given, there will usually be no necessity to give large doses, a practice which the author deplores.

Alopecia Areata.—Tattoo the affected area (which has previously been covered with a solution of *corrosive sublimate* in *glycerin*, 1 to 100) with four needles solidly mounted on a handle, or with the instrument used by oculists for tattooing the cornea. The punctures need be only slight, but sufficient to permit the penetration of the antiseptic solution into the skin. They may be frequently repeated, as the wounds are but slight and soon heal. The author has had successful results in the most inveterate cases. (M. A. MARTIN, *Gaz. des Hôp.*, July 9, 1895.)

Enuresis.—STUMPF (*Münich med. Woch.*, June 11, 1895) has successfully treated fourteen cases of nocturnal enuresis in children by elevating the pelvis. A small flat pillow is placed under the child's head and one or two ordinary pillows under the thighs, so that they lie at an angle of 130 to 150 degrees with the horizontal spine. After three weeks the patients were able to return to their former sleeping position without relapsing. The theory of the author is that elevation of the pelvis causes the urine in the bladder to gravitate back and distend the fundus instead of passing the sphincter, which is apt to become relapsed during sleep.

Goitre.—JABOULAY, of Lyons (*Bull. Méd.*, May 1, 1895), has tried the treatment of goitre by simply making an incision in the capsule and exposing the parts to the air. The goitre rapidly diminished in size and the dyspnœa and dysphonia disappeared. The operation is only suitable for cases in which the growth is surrounded by a venous net-work of considerable size or is in dangerous relations with the trachea or mediastinum. As to the mode of action the author believes that it may be attributed partly to blood and lymph changes and partly to purely trophic influences.

Gout.—STAES-BRAME (*Ann. et Bull. de la Soc. Méd., Gand*, March, 1895) recommends the continued current to cause the disappearance of an attack of gout and to prevent a fresh attack. He uses a current of 15 to 20 milliampères for ten minutes, applied to the affected joint and followed by electrization of the entire limb, one electrode being placed on the kidneys and the other on the joint, the current being increased to 40 milliampères, lowered to 0, interrupted and repeated in the same way.

Hæmorrhage after Tooth Extraction.—Pass a double-silk thread through both sides of the torn gum, either with an ordinary curved needle or a handled needle, and tie firmly over the alveolar border. Remove the stitch at the end of forty-eight hours. (JAMES MCNAUGHT, *British Medical Journal*, July 20, 1895.)

Iodine in Pharyngeal Disease.—MULLER (*Aerz. Prakt.*, June 24, 1895) protests against the practice of dissolving *metallic iodine* in *iodide of potassium*. If a local effect be desired, as in the pharynx, it is sufficient to add to the water containing the iodine from ½ to 1 per cent. of *chloride of sodium*. In pharyngeal diphtheria, for instance, he prescribes *tincture of iodine*, 1 to 2 grammes (15½ to 31 minims); *chloride*

of sodium, 2 grammes (31 grains); *distilled water*, 200 grammes (6½ fluidounces). To be applied every three hours.

Ozone in Whooping-Cough.—D. LABBÉ and P. OUDIN, of Paris (*Revue de Thér.*, July 15, 1895), are persuaded that *ozone* is of great value in whooping-cough, on account of its tonic and reconstituent effect on nutrition, and especially its antiseptic action. They employ 0.0001 gramme ($\frac{1}{660}$ grain) of *ozone* per litre of air, the patient being four or five centimetres distant from the mouth of the apparatus containing it and inhaling the *ozone* without effort as it issues from the tube. The inhalations are repeated two, three, or four times a day, according to the severity of the case, and last from ten to fifteen minutes. They are usually given a short time before meals.

Parachlorphenol.—GIRARD, of Berne, praises the antiseptic properties of this drug, considering it more stable, more energetic, and more constant in action than other agents. Its toxicity is much less than that of the soluble salts of *mercury*, *cresol*, and *phenol*. Subcutaneous injections of 1 gramme (15½ minims) per kilogramme of body-weight are required to form a toxic dose for the dog and rabbit, while 0.50 gramme (7¾ minims) of *cresol* and 0.30 gramme (4½ minims) of *phenol* produce toxic effects. As regards its antiseptic power, a 2-per-cent. solution kills the spore of anthrax in one hour, whereas a 5-per-cent. solution of *cresol* kills them only in from four to seven days, and a 5-per-cent. solution of *phenol* only at the end of twenty days. From a practical point of view parachlorphenol has incontestable advantages, dressings impregnated with it retaining their antiseptic properties much longer than *sublimate*. In infected wounds as well as in phlegmons its effects are more rapidly manifested than when *sublimate* or *phenol* are employed, though ulcers and wounds of tuberculous origin are not so favorably influenced by it. No appreciable benefit could be observed from its use in synovial disease or tuberculous affections of the joints. It is valuable for the disinfection of instruments, not attacking them any more than does a 5-per-cent. solution of *phenol*.

Pyothorax.—F. J. LUTZ, of St. Louis (*Medical Review*, June 8, 1895), in the treatment of pyothorax, determines the presence and character of the effusion by the use of the needle, and excises a portion of rib sufficiently large to permit inspection and palpation of the pleural sac. In acute cases, before changes occur in the pleura, drainage through this opening is sufficient to establish a cure.

Phthisis.—HENRI HUCHARD, of Paris, expresses the opinion (*Jour. des Praticiens*, June 8, 1895) that the future of antibacillar medication lies in inhalations. He employs a spray in the bed-room of the patient and in all the rooms that he makes use of daily, continuing this spray for an hour and a half or two hours each time. For this purpose he makes use of the large atomizer of Lucas Championnière, the glass bottle of which is about two-thirds filled with water, two or three tablespoonfuls of the following mixture being added each time the spray is

Phthisis (*continued*).

used: *Guaiacol*, 50 grammes (1½ ounces); *eucalyptol*, 40 grammes (1¼ ounces); *carbolic acid*, 30 grammes (1 ounce); *menthol*, 20 grammes (5 drachms); *thymol*, 10 grammes (2½ drachms); *essence of cloves*, 5 grammes (1¼ drachms); *alcohol*, at 90°, sufficient to make 1 litre (quart). The spray is used in the morning on awakening, in the evening on retiring, and once or twice during the day. By this method he obtained the recovery of a patient in the second stage of tuberculosis, after eight months of treatment. During all this time the woman remained in her rooms, breathing continually air charged with these vapors. Jaccoud, who saw her at the beginning and end of the treatment, confirms the fact of her recovery. Under the influence of the inhalations, which constituted the only measure of treatment, the bacilli first diminished and then disappeared; the sweats, cough, and expectoration also disappeared, the general condition greatly improved, and the patient gained 8 kilogrammes (17½ pounds) in weight. There is now a slight murmuring respiration on the right side, indicating, according to Jaccoud, the fibrous and curative transformation of the tuberculosis.

TURCHET finds *milk* an excellent excipient for *guaiacol* when it is desired to give rectal injections of this drug in phthisis. A solution of 1 part of *guaiacol* to 20 or 30 parts of *milk* will keep indefinitely without coagulating and can be readily mixed with water when it is desired to make the injection; or if it be deemed preferable to add the *guaiacol* to the *milk* at the moment it is to be used, it need only be remembered that 1 gramme of the drug contains 38 drops.

ANNEQUIN regards injections as the most satisfactory method of administering *creasote* in tuberculosis, and for three years he has employed no other method. He uses, in his hospital work, 20, 40, or 60 grammes (5, 10, or 15 drachms) of a 1 to 20 solution in milk and adds sufficient boiled water to make 250 grammes (8 fluidounces). In private practice he advises a 1 to 30 solution, 2 tablespoonfuls being used when an injection of 1 gramme (15½ minims) of *creasote* is desired; or the *creasote* may be dropped directly into the milk, 43 drops (constituting 1 gramme) being placed in one-quarter of a glass of milk, and the glass then filled with water. (*Jour. de Méd. et de Chir. Prat.*, July 10, 1895.)

J. W. CHISHOLM, of New Concord, O., obtains the best results in phthisis, with the least degree of constitutional disturbance, from inhalations of *creasote*, using what is called a *muriate-ammonia* inhaler. In this he places 1 ounce (31 grammes) each of commercial *hydrochloric acid* and *sulphuric acid*, which have been carefully mixed in a glass mortar, and drops into it from 20 to 30 drops of a solution of *beech-wood creasote*, 1 drachm (4 grammes) in *alcohol*, 4 drachms (16 grammes). The inhalations are given several times during the twenty-four hours (*Columbus Medical Journal*, July 23, 1895.)

Recumbent Position in Labor.—T. RIDGWAY BARKER, of Philadelphia (*New York Medical Journal*, July 6, 1895), questions the necessity of keeping the puerperant in the recumbent position longer than four days. He is in favor of the semirecumbent position after that time, as being more comfortable, facilitating nursing, and improving drainage *per vaginam*. The patient, if a primipara, may leave her bed in three weeks; if a multipara, and there are no complications, in two weeks. Going up and down stairs in all cases had best be postponed until the fourth or fifth week.

Sutures in Gynæcology.—J. M. BALDY, of Philadelphia, uses catgut for sutures in his hysterectomy cases, finding that convalescence is rendered less tedious and uncertain. (*Am. Journ. Obstet.*, June, 1895.) He still retains silk for ligating the uterine and ovarian arteries, not being yet satisfied to trust to the strength of catgut, the more so as the latter is apt to be weakened by overpreparation in rendering it sterile. NOBLE uses only the silk ligature, and has never had any trouble. A large silk cord is apt to give more trouble than a small thread, partly because the ligature is tied more tightly, reducing the vitality of the stump, and partly because if a large ligature is infected the white blood-cells are less able to combat the resultant septic processes about the ligature. He has been using silk-worm gut as a buried suture for abdominal wounds for three years, and out of several thousand such stitches he has had trouble in but three cases, in which suppuration took place in dead spaces. E. C. DUDLEY, of Chicago, uses catgut entirely in the abdominal cavity, and has had no occasion to regret its use. A. MACLAREN, of St. Paul (*Med. News*, June 15, 1895), advocates the use of catgut in gynæcological operations, prepared by steam and dry sterilizing, a sufficiently high temperature being used for the necessary time to destroy germs without rendering the catgut brittle.

Tachycardia.—H. DESPLATS, of Lille (*Jour. des Sci. Méd.*, No. 23, 1895), insists on the value of large doses of *digitalis* (0.75 gramme—11½ grains) of the powder or 5 or 6 granules of *digitaline*) in essential paroxysmal tachycardia. He prefers this drug to treatment by milk diet and rest. *Bromide of potassium*, in daily doses of 5 grammes (1¼ drachms), given in the intervals, appeared, in his hands, to diminish the number and length of the attacks.

Thirst following Cœliotomy.—Prepare the patient as usual, by diet, daily baths, cathartics, etc. For three days prior to operation, order her to drink 1 pint (500 grammes) of hot water an hour before each meal and on retiring, making 2 quarts (litres) of water each twenty-four hours, the last pint to be taken three hours before the time set for operating. Do not omit the water the day previous to the operation, while the patient is restricted to a limited amount of liquid nourishment and the bowels are being unloaded. The large loss of fluid occasioned by the free catharsis is thus compensated for, and the patient passes through

Thirst following Cœliotomy (*continued*).

the trying ordeal of the first thirty-six hours after operation in comparative comfort, with no thirst, a moist tongue, and an active renal function, represented by an excretion of from 28 to 50 fluidounces (868 to 1550 grammes) of urine during the first twenty-four hours, catheterization being seldom necessary. This is quite in keeping with the full character of the pulse noted. (W. H. HUMISTON, *American Journal of Obstetrics*, July, 1895.)

Traumatic Tetanus.—J. C. CAMERON, of Montreal (*Journal of Mental and Nervous Disease*, June, 1895), found *chloral* of more value than *opium* in a case of traumatic tetanus under his care. Sometimes the good effect of a 20- or 30-grain (1.3 or 2 grammes) dose would last for a day or longer, while that of a 10 grain (0.65 gramme) dose barely lasted four hours. He would in future be inclined to try larger doses at longer intervals.

Monographs Received.

The editor acknowledges, with thanks, the receipt of the following monographs:—

Fibrino-plastic Exudates. By **D. Braden Kyle**, Philadelphia.——Leucomaine Poisoning. By **B. K. Rachford**, Cincinnati.——Forcible Alveolar Expansion in the Treatment of Consumption. By **W. H. Weaver**, Chicago.——Observations of a Country Practitioner Relative to Quinine. By **A. A. Young**, Newark, N. Y.——Bulletin of the American Academy of Medicine, June, 1895.——A Case of Hematidrosis Combined with Chromidrosis. By **Isadore Dyer**, New Orleans.——Nuovo Apparechio d'Intubazione laryngea semplificato. By **F. Egidi**, Rome.——Exploratory Pleurotomy and Resection of Costal Pleura. By **Carl Beck**, New York.——Fifth Annual Report of the Eye, Ear, Nose, and Throat Hospital, New Orleans.——Report of the Diphtheria Antitoxin Commission of New Orleans, November, 1894, to March, 1895.——Hypnotism: its Uses, Abuses, and Medico-Legal Relations. By **William Lee Howard**, Baltimore.——Proceedings of the Connecticut Medical Society, 1894.——The Technique and Indications of Vagino-fixation (Mackenrodt's Operation). By **Hiram N. Vineberg**, New York.——The Quadrangular Cartilage of the Septum, Miscalled the Triangular. By **Walter J. Freeman**, Philadelphia.——The Care and Disposition of Persons Found Unconscious on the Streets or Elsewhere. By a special Committee of the Brooklyn Medical Society.——Vegetable Nucleo-toxin in the Treatment of Cancer. By **J. E. Chambers**, St. Louis.

☞ ***Any journals, exchanges, reprints, monographs, or books not sent directly to the editorial office, 28 rue de Madrid, Paris, will not receive attention either in the "Annual" or the "Universal Medical Journal."***

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No. 28, RUE DE MADRID, PARIS, FRANCE.

(End of Editorial Department of Journal for August, 1895.)

The Effect of Cold Baths.

THE marked improvement in the treatment of typhoid fever and pneumonia by the employment of cold baths ought to attract more attention from the general practitioner. Doubtless, the published reports would have more effect were the contributors to undertake a rational explanation of the *modus operandi* by which these great benefits are secured. It is scarcely sufficient, in these latter days of thorough investigation, to simply state that a remedy or method has accomplished such and such results. The better class of practitioners want to know why these results have been obtained, and how it is possible that such favorable reports can be presented from adopting a routine that apparently has no real scientific foundation. That is, it has no foundation, in their opinion, because it does not involve the administration of drugs.

The theory of the cold-bath treatment of typhoid fever and pneumonia has not yet been fully demonstrated, but the good effects cannot be denied. We, therefore, commend to the attention of our readers the reference to this subject in the present number, by Dr. PEYSER, and believe it will well repay careful perusal and study. In the opinion of the writer, the benefits arising from cold baths are due largely to the fact that these applications institute an artificial leucocytosis, and if we can manage to maintain nutrition during the current illness the effect upon the disease will be most favorable. Let us see if we cannot inject this physiological idea into other methods of treatment, and thus lessen the demand for drugs.—*American Therapist*, August, 1895.

Clinical Experiences with Solutions of Pyrozone.

H. C. RAYMOND, D.D.S., says: "I take pleasure in saying that I have been using the pyrozone solutions for several months, and have found the results highly satisfactory. It is, indeed, gratifying to know that a drug so valuable as hydrogen dioxide has been made stable and so free from acid. This will unquestionably widen its field of usefulness in dental surgery.

"As a bleaching agent I have had some excellent results with the 25-per-cent. solution, and it promises to be exceedingly useful in the treatment of pyorrhœa alveolaris, though I have not been using it long enough in that direction to feel justified in making any definite statements.

"The 5-per-cent. solution I use largely in setting crowns and bridges, its styptic qualities rendering it extremely valuable in arresting any bleeding, and in effectually stopping up the pores through which moisture will find its way. Operators in crown and bridge work who have not used pyrozone for this purpose have no idea what an aid it is in keeping the parts perfectly dry. I prescribe 3-per-cent. pyrozone for my patients, to be used as a mouth-wash just before retiring, and specially urge its use to those wearing plates and crowns, or bridges, for its prophylactic qualities are, in my opinion, inestimable."

THE

Universal Medical Journal.

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Selections from Society Proceedings.

BELGIUM.

SECOND INTERNATIONAL CONGRESS OF MARINE HYDROTHERAPY, OSTEND.

Pulmonary Phthisis at the Sea-shore.—DR. G. HOUZEL, of Boulogne-sur-Mer, stated that, in deciding as to the advisability of sending patients suffering from pulmonary disease to the sea-side, it must be ascertained whether the cases are suited to the stimulating atmosphere. If the disease is slow in progress and the individual lymphatic, or, so to speak, scrofulous, the marine climate will, without doubt, prove beneficial. If, however, there be fever, hæmoptysis, or cavities of any size, or if the individual be of a nervous or arthritic diathesis, the air of the sea will produce a fatal excitation, and should be avoided. Sudden changes of temperature and violent winds should be avoided, and a sunny resort, protected by hills from cold winds, especially of the north and east, selected. The breeze from the sea is mild and beneficial, that from the land is to be feared, and for that reason many sea-side resorts are unfitted for phthisical patients in the winter.

DR. J. CASSE, of Middlekerke, did not regard hæmoptysis as a formal contra-indication. He had seen two patients who had had severe hæmorrhage much benefited by a sojourn at the sea-side, and he knew of no case in which an initial hæmorrhage had occurred there. He believed that phthisical patients would find themselves under better conditions for recovery owing to the purity of the air and the climatic advantages enabling them better to resist the progress of the disease.

DR. FRIEDRICH, of Dresden, quoted the statistics from the German littoral of the North Sea, showing the happy influence of the latter on the mortality of phthisis, the death-rate being only 4 per cent. among 100,000 inhabitants. The island of Heligoland also showed a low mortality. He

did not regard hæmorrhage as a contra-indication, but considered such cases better off at the sea-shore than at the mountains. Certain cachectic cases complicated by laryngeal phthisis do better at the southern health resorts, as the Riviera.

FRANCE.

Société Anatomique, Paris.

Aneurisms of the Heart.—Three cases of aneurism of the heart have recently been presented before the society. The first case, described by Gouget, was that of a woman, 56 years of age, with a history of left-sided pneumonia. She suffered from great dyspnœa, perimalleolar œdema, congestion at the base of both lungs, and cardiac hypertrophy. There was no murmur or arhythmia, the first sound being simply reduplicated at the apex. The patient soon died with asystole, and a post-mortem examination showed pericardial adhesion and aneurismal dilatation of the anterior surface of the ventricle, with fibrinous clots adherent to the wall. There was no coronary lesion, but a cardiac kidney with beginning sclerosis. Histological examination revealed advanced sclerosis of the wall of the ventricle outside the seat of the aneurism, small patches of fibro-elastic tissue being found, containing dissociated and atrophied muscular fibres. The wall of the aneurism contained only some remains of muscular fibre, imbedded in fibrous tissue, continuous with the endocardium and pericardium, which were also thickened. The case was thus one of diffuse aneurism depending on myocarditis, and explaining why Leyden admitted an "aneurismal form of myocarditis." Possibly the pericardial adhesion played some rôle in the case, which is interesting as showing that interstitial myocarditis, at an advanced stage, with or without aneurism, may assume the form of Bright's disease.

The second case, that of René Marie and Rabé, is entirely different from a pathological stand-point, though here also a diagnosis of Bright's disease was made during life. The patient was an alcoholic man of 55 years, without pathological antecedents, who showed for a period of two months marked albuminuria, slight malleolar œdema, cardiac *bruit de galop*, mania, general weakness, frequent palpitation without angina pectoris, and suffocative attacks at night. At the autopsy soft adhesions to the left ventricle and apex were observed, the wall being suddenly thinned at the apex, where the endocardium formed a sort of collar, the aneurism being circumscribed and not diffuse. The sac was lined with fibrinous clots, and the left coronary artery was completely obliterated from within three and one-half centimetres of its origin, the area of sclerosis exactly corresponding to the distribution of its branches. The case was, therefore, one of infarct from obliteration of a coronary artery.

The third case, seen by Claude, was similar to the second, being a circumscribed aneurism of the apex of the heart, due to alteration of the anterior coronary artery, which was atheromatous and diminished in calibre. The patient, a woman 67 years old, entered hospital with right hemiplegia

following an apoplectic seizure. There was apparently no cardiac lesion nor albuminuria, but slight atheroma. A diagnosis of cerebral hæmorrhage was made, but autopsy showed the case to be one of cardiac aneurism.

If sclerosis of the coronaries may lead to the formation of an infarct, atheroma of the aorta may lead to the formation of an aneurism, as demonstrated by a case presented to the society by SERGENT. This was an enormous aneurism of the arch of the aorta, formed by three pockets,—a first in the vessel-cavity, a second behind the sternum and ribs, and a third in front of the sternum, under the skin. The aortic ectasia had destroyed bone and cartilage and penetrated beyond the thoracic cavity. An interesting clinical point is that this superficial pocket burst twice under the influence of traumatism, the hæmorrhage being successfully controlled, and it was only after a third rupture that the patient died.

Pneumonic Nephritis Preceding Pneumonia.—CAUSSADE described a case proving that the pneumococcus may affect the kidney several days before the signs of pneumonia proper become evident. His patient was a man of 50 years, who entered hospital with all the signs of acute nephritis,—anasarca, oliguria, cloudy urine with considerable albumin, pulmonary œdema, and dyspnœa. These symptoms had come on quickly, and in four or five days the temperature rose rapidly from 38.5° to 40° C. (101.4° to 104° F.). Two pneumonic areas were ascertained to exist on the left and right sides. Death occurred eight days later, and at autopsy the diagnosis of acute nephritis with large white kidney and double pneumonia in the stage of red hepatization was confirmed. Microscopical examination showed dilatation of the convoluted tubules, fragmentation of the epithelial cells, and a fibrinous exudate analogous to that found in the pulmonary alveoli in pneumonia. The glomeruli were relatively intact. The Talamon-Frænkel bacillus and some streptococci were found in the vessels and convoluted tubules.

It would appear that there are three kinds of pneumonic nephritis,—the prepneumonic, the pneumonic, and the metapneumonic.

CONGRÈS DE GYNÉCOLOGIE, D'OBSTÉTRIQUE, ET DE PÉDIATRIE, BORDEAUX.

Detachment of the Membranes in Premature Artificial Delivery.—KUFFERATH, of Brussels, described a simplified method of detaching the membranes in induced labor. It consists in irrigation of the inferior segment with sterilized water or boric-acid solution, using an Esmarch glass irrigator joined by a rubber tube to a glass S-shaped cannula half a centimetre in diameter. Moderate pressure is employed in the irrigation, the vulva and vagina being previously rendered aseptic. The danger of introducing air into the uterine cavity is avoided by using a pressure of fifty centimetres and letting the liquid flow as the sound is being introduced. One to two litres (quarts) of fluid are usually sufficient, and if pains occur the irrigation is discontinued for a time. Labor usually sets in in from five to six hours. In fifteen cases in which the author employed the method, no accident occurred.

LAZAREWITCH stated that he had also tried the method, but had found

it very slow, it being necessary to repeat the irrigation thirteen times before obtaining the desired result. He had been more successful with deep injections of only 100 grammes (3¼ ounces) of fluid, using a long sound.

TARNIER, of Paris, regarded Kufferath's method as a good one, but said that he could not help recalling two cases in which the use of Kiwich's douche was followed by sudden death. It was after one of these accidents that he had invented his dilator.

Incoercible Vomiting in Pregnancy.—AUDEBERT recommended, in certain cases in which it was necessary to induce abortion, the emptying of the uterus of its entire contents in a single *séance*. For this purpose he prefers the curette, preceded by dilatation with Hegar's tents. The advantages of such a procedure are the rapid and certain action, the total evacuation of the uterine contents, the suppression of reflex troubles such as vomiting, the reduction of hæmorrhage to a minimum, and the absence of danger when prudence and asepsis are observed. The author regarded the method as particularly indicated in cases of vomiting in the early months of pregnancy.

VULLIET, of Geneva, remarked that in several such cases in which he had completely curetted the uterus he had the placenta expelled intact and spontaneously the following day. Generally speaking, it was wrong to cause a too hasty expulsion of the fœtus, and better to wait.

CORDES, of Geneva, regarded quinine internally as an excellent adjuvant, as it hastens rapid dilatation and facilitates the introduction of Champetier's bag, which, in his opinion, was the instrument of choice.

EUSTACHE, of Lille, had succeeded in arresting vomiting by puncture of the membranes. GRYNFELTT also favored this plan.

AUDEBERT stated that after having curetted it was well to introduce the finger into the uterus in order to ascertain that nothing remained, and to remove any fragments that might be found.

Vulvo-Vaginal Leukoplakia and Cancer.—M. E. MONOD, of Bordeaux, said that vulvo-vaginal leukoplakia, though much more rare than leukoplakia of the mouth, is practically identical with that affection. Like it, it shows a marked tendency to undergo epitheliomatous transformation, and it is one of the causes of primary cancer of the vulva and vagina. When the condition exists the indication is to remove, by way of prevention, the affected parts, when the limited number of white patches allows that to be done without too great mutilation. Where the lesions are confluent the case should be kept under careful observation, so that surgical intervention may be made at the slightest suspicious appearance. Epithelioma of the vulva and vagina, when it can be definitely recognized, should be completely removed at the earliest possible moment; but the chances of recurrence, either local or in the glands, is very great.

SOCIÉTÉ DES SCIENCES MÉDICALES DE LYON.

Cause of Nausea from Morphine.—L. GUINARD, of Lyons, from a series of experiments on cats and dogs, concludes that the nausea which sometimes precedes the hypnotic effect of morphine is produced in the same

manner as that caused by apomorphine,—that is, by a direct action upon the nausea centres of the bulb, exciting before narcotizing them. (*Lyon Méd.*, September 8, 1895.) When very large doses are injected the narcotic effect is produced first, thus explaining why vomiting occurs more freely when small quantities are given. The fact that such vomiting is not constant and varies in different persons the author explains by an individual variation in the susceptibility of the nerve-centres and a greater or less power of resistance. The association of atropine with morphine to prevent vomiting from the latter drug is not always successful in animals, and its action is a synergic rather than an antagonistic one.

M. Soulier insisted upon the value of atropine in combating nausea due to morphine injections in practice, and M. Icard stated that he had not for years used a solution of morphine that did not contain atropine. The only danger is that the patient is exposed to intoxication by atropine if the number of injections is increased.

GERMANY.

Hamburg Medical Society.

Varioliform Exanthem following Measles.—Professor Unna described an interesting case in which a varioliform eruption developed in a child 1 year old while recovering from an attack of measles. The etiological factor was ascertained to be the streptococcus. In the most recent vesicles the micro-organism was found only in the blood-capillaries, especially in those of the papillary body. An extensive fan-shaped colliquation had already occurred, with necrosis of the cutaneous surface as in variola, the centre of the lesion being a thrombus with cocci. In a more advanced stage the streptococci were found to have penetrated into the lymph-spaces of the papillary body and the cavity of the epidermic lesion, especially invading the periphery. In a third stage the entire cavity was filled with the micro-organisms, which diminished progressively in number toward the skin.

From the progress of the bacterial invasion Professor Unna concludes that an eruption having the same structure as the pustules of variola may occur without the involvement of the epidermis, but simply through the presence of the bacteria in the capillaries of the papillary body; and, further, that thrombosis of the vessels of the skin may occur without hæmorrhage. The microbes of purpura must therefore secrete toxins having a special action on the endothelial walls of the capillaries.

The case also shows that organisms of rapid growth may lodge in the skin and fill the periglandular capillaries without being eliminated by the sweat, as has been claimed.

GREAT BRITAIN.

British Medical Association.

The Antitoxin Question.—Bacteriology and its offspring, antitoxins, formed almost the sole topics of discussion in the Section of Medicine. According to the *Practitioner* (September), diphtheria, pneumonia, and acute rheumatism were the subjects selected by the authorities for the formal debates, and in each of them the iniquitous and ubiquitous microbes were held responsible as the causative factors, although with some difference in the degree of guilt. Thus, no doubt was expressed as to the influence of the bacillus diphtheriæ in originating that malady. The activity of the pneumococcus was held by many, but not by all, to be responsible for the second complaint, most speakers agreeing that other conditions were also present; whilst as to rheumatism the microbic origin of the disease is inferred, and extremely probable, although at present not proven. Perhaps the chief point of interest in connection with the latter affection is the diversity of manifestations which are now ascribed, and apparently with justice, to a rheumatic origin. Thus, not only are the joint affections considered of this nature, but also many cases of tonsillitis, chorea, erythema, as well as the peri- and endo- cardial inflammations so often seen. The generally expressed opinion was that while some of these were caused directly by the microbe —*e.g.*, the arthritic conditions—others, such as chorea, were induced by the action of the toxins of the theoretical organism. Further investigations will be most anxiously awaited to ascertain whether this interesting conjecture is true or false. One voice was certainly raised against it in the most emphatic manner,—viz., that of Dr. Haig, who, as is well known, maintains that all such conditions can be just as well explained by the theory that they are due to an abnormal formation of uric acid. It has been objected to his ideas that no evidence as to the existence of an undue amount of uric acid in the blood can be found. "Quite so," he replies; "it is not in the blood, because it is causing mischief by its presence in the joints, or elsewhere." Then, too, he emphasizes the influence of diet on the disease, all those food-stuffs being harmful which tend to increase the amount of uric acid in the system. Turning now to the therapeutic side, nothing of an antitoxic nature can be suggested in rheumatism until the organism, if one exist, has been isolated; and hence the use of salicin and its derivatives has not been superseded. In pneumonia an antitoxin was talked of by one or two speakers, but nothing very definite has as yet been accomplished along these lines. Salines are to be depended on as a general rule, and in certain conditions other drugs, such as caffeine, strychnine, antipyrin, etc., must be employed for the treatment of symptoms. Really the chief interest of the section centred around the discussion on the use and value of the diphtheria antitoxin. In opening the discussion Dr. Martin stated that one of the chief aims of physicians in the past has been to discover some means of loosening the false membrane, and that comparatively little notice had been taken of the general symptoms. Since the discovery of the true nature of the disease,—viz., that toxic bodies are produced and absorbed from the

false membranes which act directly on the nerve-centres,—and since it has been demonstrated that bacilli in their growth produce substances capable of restricting their own activity, or of counteracting the effects of their own growth, micro-pathologists have been working at the means of producing and separating these valuable bodies so as to render them accessible to the practitioner. The success of the treatment of diphtheria by this means is on all hands admitted to have been very great, and perhaps no better evidence of this can be adduced than the statistics brought forward in the course of the discussion by PROFESSOR VON RANKE, of Munich. He stated that in 1892 his hospital mortality was 52.2 per cent.; in 1893, 46 per cent.; whilst in 1894, up to September, it was 57 per cent. Since the introduction of the antitoxic serum in that month his death-rate has been reduced to 17.7 per cent. PROFESSOR BAGINSKY, of Berlin, was able to report a similar diminution in his mortality, which had fallen from 41 to 15.6 per cent. No evident evil effects had resulted from the injection of the serum, in the experience of most of the speakers, and thus this reagent received from international testimony a most commendatory *imprimatur* and its value must henceforth be appraised at a high standard.

Indications for Early Radical Treatment in Malignant Disease of the Larynx.—The discussion on this subject was introduced in a well-balanced and judicial paper by DR. BRYSON DELAVAN, of New York, who set forth clearly his views as to when the operation should be undertaken and the requisites in order to insure success. (*Practitioner*, September, 1895.) It must never be looked on as a simple proceeding or as one devoid of risk, and its execution should be limited to those who can be so well assisted and who can command such experience and skill as shall insure as far as is possible a successful issue. MR. BUTLIN entered somewhat more fully into the minutiæ of the surgical technique, and remarked that, judging from the statements and writings of American and Continental *confrères*, the subject of laryngectomy is further advanced in this country than anywhere else. The general idea running through the animated debate which ensued was that the all-important essential was an early diagnosis, and this could only be the result of the general recognition of the principle that every case of persistent hoarseness must be examined by a skilled laryngologist as soon as possible. In cases of doubt an exploratory thyrotomy is quite justifiable, and in this way it might be anticipated that the disease would be recognized before it had attacked the cartilages, and could then be dealt with by cutting or scraping the new growth away, without necessitating the removal of the larynx. In fact, the hope was expressed that in the future laryngectomy would be looked on as the opprobrium of laryngologists.

Treatment of Pruritus.—PROF. MCCALL ANDERSON, of Glasgow, enumerated the nervous elements participating in pruritus as follows: The terminal ramifications of the cutaneous nerves in the epidermis; the small groups of cells communicating with the nerve-filaments and situated in the deep layers of the epidermis and in the superficial layers of the derm; and, finally, the hairs, which being, properly considered, organs of touch, may cause pruritus by irritation of their follicles. It is difficult to say why

pruritus manifests itself in some cutaneous affections and not in others, or why the early manifestations of syphilis are not pruriginous, while the later cutaneous lesions of the disease are distinctly so. Among the most important etiological factors are senility, icterus, gout, digestive disturbances, diabetes, seasonal influences, and nervous and psychical disorders. Without denying the rôle of reflex irritations, Dr. Anderson expressed the belief that, in most cases, the itching sensation is due to direct irritation of the nerve-endings in the epidermis.

Treatment should be directed against the supposed cause of the affection, and, should it fail, empirical measures may be tried. Local applications are of but secondary importance, internal medication being usually more efficacious. Among these the best is gelsemium sempervirens, tincture of cannabis Indica, carbolic acid, and, especially, atropine hypodermatically, as well as antipyrin and phenacetin in progressively increasing doses. Electrotherapy also gives good results. In debilitated subjects tonics, such as phosphorus, arsenic, and strychnine, are also indicated.

Dr. Myrtle, of Harrowgate, called attention to the difficulty of treating the disease, owing to individual peculiarities of the patients. Remedies found useful in one case are injurious in another exactly similar. The best drugs in his hands have been the coal-tar derivatives and chloral. In severe cases applications of a 3- or 6-per-cent. solution of caustic potash to the affected parts give considerable relief.

Dr. Waldo, of Bristol, stated that a blister applied over the spine, on a level with the affected region, often gave good results, while in the pruritus due to osteo-arthritic affections sodium salicylate internally was beneficial.

Dr. Stopford Taylor, of Liverpool, placed little faith in internal medication, but recommended hygienic measures, proper food, and physical exercise. Frequent change of linen and alcoholic lotions are serviceable in the anal pruritus of bicyclists.

Dr. Barendt, of Liverpool, reported good results from the application of 2-per-cent. carbolized olive-oil to the affected parts for about five minutes at a time.

General Therapeutic Effect of the Alternative Electric Current of High Frequency and High Tension.—Dr. G. Apostoli, of Paris, who, together with Dr. Berlioz, presented a paper on this subject to the Academy of Sciences of Paris on the 18th of March, 1895, now, after further experience, presents a summary of his conclusions, as follows: According to d'Arsonval's discoveries, alternative currents of high frequency and of high tension exert a powerful action upon all living bodies submitted to their inductive influence. The best method of applying these induced currents is to place the patient, free from all contact with electrodes, in the circuit of a large solenoid traversed by these currents. The patient being thus completely insulated, the currents, which circulate in his body by auto-conduction, have their origin in his tissues, the body playing the rôle of a closed induced circuit. By this method the physiological discoveries of d'Arsonval are confirmed and we are able to prove the powerful influence of these currents upon the vasomotor system; although they produce absolutely no sensa-

tion and have no apparent effect upon the motor or sensory nerves. They have, nevertheless, a powerful action upon all the nutritive functions, as verified by d'Arsonval's numerous analyses of the gaseous products of respiration and by Berlioz's not less numerous analyses of the urinary excreta. The general therapeutic applications to be deduced from this physiological action are confirmed by clinical observation.

Dr. Apostoli has now treated more than a hundred patients by this method at his clinic and at his private consultation rooms. The greater number of these patients have been much benefited by this new treatment, which has been used to the exclusion of all other forms of medication, dietetic or otherwise. These currents exert, in the majority of cases, a most powerful and generally beneficial action upon diseases due to slackening of the nutrition by accelerating organic exchanges and combustion This is proved by analyses of the urine made by Dr. Berlioz. The quantity becomes more normal, the products of organic waste are better eliminated, and the increased combustion is shown by the diminution of uric acid, while the percentage of urea is generally increased. The relative proportion of these two substances changes under treatment so as to reach in general the figure of 1 to 40. The elimination of the mineral products is also changed, but in a less marked manner.

When daily *séances* of fifteen minutes are given we may generally observe in the patients (1) a return of sleep; (2) an increase of strength and vital energy; (3) an increase of gayety, of power for work and ability to walk; (4) an improvement in appetite, etc. In short, a general progressive improvement. This general improvement often manifests itself after the first *séances*, before any local influence is apparent and before any change has occurred in the urinary secretions. Local pain and trophic changes are often more slowly affected, and at times are entirely refractory for a longer or shorter period. In such cases the same currents must be applied locally by contact with the electrodes.

The diseases which have appeared incurable are those not associated with well-defined organic changes, such as hysteria and certain forms of neurasthenia. Dr. Apostoli has also observed that certain localized neuralgias are refractory to this form of currents, requiring a more direct local application. The diseases which have derived most benefit belong to the arthritic class,—rheumatism and gout. In certain diabetic subjects the sugar disappeared altogether from the urine, while in others there was no such change, notwithstanding the manifest and constant improvement in the general condition. Is this difference due to the imperfection of the electric apparatus, or to the manner of its application? It is hoped that further experience will soon afford an answer to this question; although the fact that diabetes has many different causes may in itself explain the difference in the results obtained by this treatment.

In conclusion the author asserted that currents of high frequency and of high tension greatly increase the field of medical electricity and furnish general medicine with a new and valuable means of treatment capable of modifying more or less profoundly the process of nutrition.

Electrotherapy as a Means of Diagnosis in Gynæcology.—Dr. G. Apostoli, of Paris, after a long and thorough trial of his method, has come to the following general conclusions: 1. The faradic current of tension (generated by the coil of long and fine wire) applied to the uterine cavity, according to the rules established by him in 1883, relieves, for a longer or shorter time, all ovarian pain of nervous or hysterical origin, but remains powerless, or nearly so, in case of ovarian pain caused by inflammatory lesions of the periuterine tissue or of the appendages. 2. The same faradic current is therefore useful in diagnosis, inasmuch as it helps us to distinguish the nature of so-called ovarian pain, and to determine rapidly the differential diagnosis between hysterical and inflammatory ovarian pain. Where the two kinds of pain exist in the same patient we are helped to understand their nature by the fact that the one is relieved and the other is not. 3. If, then, the curative effect of the faradic current clear up or rectify a doubtful diagnosis, it protects us at the same time from undertaking a useless operation. On the other hand, if the same faradic current prove ineffective, the lesion being inflammatory, we are led to resort to a supplementary galvanic treatment or to a surgical operation sooner or later. 4. The constant galvanic current, applied to the uterine cavity in doses gradually increasing from 50 to 120 milliampères, according to the rules published by him in 1884, and bearing in mind individual susceptibility and tolerance, will be almost always supported without much pain during the *séance*, and without febrile reaction afterward, if the parts adjacent to the uterus are free from inflammation. Simple cystic, periuterine tumors, which are neither inflamed nor suppurating (such as ovarian cysts and hydrosalpinx), may also show perfect tolerance of the galvanic current. The galvanic current is also sometimes perfectly supported by cases in which the uterus is surrounded by old inflammatory products or exudations no longer pathogenic. 5. There are three classes of cases which should be considered as exceptions to the preceding rule, for they bear the galvanic current more or less badly, though they do not necessarily produce much febrile reaction after the *séance*. They are: (*a*) certain forms of hysteria; (*b*) fibrocystic tumors of the uterus; (*c*) enteritis with false membrane. It is generally easy to diagnose these cases of intolerance. 6. All acute periuterine inflammation (of the pelvic cellular tissues, of the peritoneum, and especially of the appendages) will cause the galvanic current to be badly borne when it passes 40 or 50 milliampères, and will cause intolerable pain and febrile reaction when carried beyond this intensity. 7. The intolerance for the galvanic current is generally proportionate to the extent and gravity of the lesions referred to and increases with the intensity of the current employed, especially when it passes 40 or 50 milliampères. 8. All inflammation of the appendages which is curable (symptomatically at least) without radical operation will bear the galvanic current better and better, and there will be a corresponding improvement of the prominent symptoms such as pain and hæmorrhages. The intolerance noted at the beginning progressively disappears. 9. All grave inflammatory lesions of the appendages, and notably all suppurative processes which are incurable (even symptomat-

ically) by conservative means, show the same intolerance from the beginning to the end which was noticed at first, and which is apt to increase instead of diminish if the treatment is continued. 10. Thus, the simple study of the tolerance or intolerance of the intra-uterine galvanic treatment, and especially of the post-operative pain and fever occurring on the evening of or the day following the treatment, enables us to make the diagnosis. It also, in four or five *séances*, given twice weekly, informs us of the condition of the appendages, of their possible inflammation and its degree, and in this way it lessens the number of laparotomies and exploratory incisions. 11. The same study of the so-called galvanic reactions also informs us rapidly (in five to ten *séances*) of the curability of those inflammatory lesions which the electric current has demonstrated, and in consequence of this it tells us in one case to abstain from operation, while in another it shows an operation to be urgent. 12. *En résumé*, gynæcological electrotherapeutics, carefully, methodically, and patiently applied, instead of being opposed to the marvelous progress of surgery, comes to its aid. Independently, in fact, of the great therapeutic service which it renders every day, electricity serves as a touch-stone; it assists us in diagnosis and thus directly serves the interests of surgery, in one case showing an operation to be useless and dangerous, in another that its necessity is urgent. Thus, many laparotomies, so-called exploratory incisions, and mutilations practiced without due deliberation for the relief of rebellious ovarian pain or for lesions of the appendages of uncertain nature, should be, from this time forth, delayed or formally proscribed until all the resources of faradic sedation on the one hand and of the intra-uterine galvanic effect on the other have been tried. Experience has abundantly proved these currents to be innocuous, if given with necessary aseptic precautions.

Edinburgh Obstetrical Society.

The Maternal and Fœtal Blood at Birth.—Drs. George Elder and Robert Hutchison gave the result of their observations on the blood of mothers and healthy children immediately after birth, the blood being obtained from the umbilical cord when it was cut and from the lobe of the ear in the mother during the latter part of the first or during the second stage of labor. The following is a summary of their conclusions (*Edinburgh Medical Journal*, August, 1895):—

1. The blood of the newly-born child is relatively richer in red corpuscles than that of the adult by 850,000 to 500,000 per cubic millimetre.

2. For a short time after birth (up to about two days) the red corpuscles seem to increase in number. This is probably due to the fact that the total volume of blood is less, from the fluid lost from the body during this time being in excess of that absorbed. Thus concentration of the blood is produced. After the second day or so the red corpuscles gradually decrease.

3. The number of red corpuscles varies much more than in adults, probably because of greater variations in the total volume of the blood.

4. At birth there is always present a considerable number of nucleated red corpuscles. They vary, however, in number in different cases.

5. About the sixth month of intra uterine life the number of nucleated red cells is very much greater than at birth. They probably rapidly decrease in number during the later months of pregnancy, and altogether disappear from the blood a few days after birth.

6. The blood of the newly-born child is relatively much richer in hæmoglobin than the blood of the adult.

7. Not only is this so, but the individual red corpuscles are richer in hæmoglobin than those of the adult.

8. The blood of the mother at parturition is anæmic.

9. In any individual case the blood of the mother is considerably poorer in red corpuscles per cubic millimetre than that of her child, and it is still more deficient in hæmoglobin.

10. Both the blood of the mother and that of the child contain a larger number of white corpuscles than normal adult blood. The blood of the mother may be quite as rich in white corpuscles as that of the child.

11. The blood of the child contains a distinctly larger proportion of lymphocytes and a distinctly smaller proportion of neutrophile leucocytes than the blood of the adult; the number of eosinophile cells seems to be slightly deficient.

12. At the sixth month this excess of lymphocytes is probably even more marked than at birth; they probably decrease during later months of pregnancy.

13. After parturition the number of white corpuscles in the blood of the mother (at least, of those who suckle their children) decreases markedly in a few days.

Although most of these results have already been obtained, yet a consideration of them is of interest, whether one looks to the vital processes going on during intra-uterine life or to the question of the life-history of the cell-elements of the blood. We intend at present only to refer briefly to one or two of the more prominent ones. The great difference between the constitution of the blood of the mother and that of her child would altogether dispose of the idea of any mixing of their bloods, even if histological investigation had not already proved that this did not occur. The remarkable richness of the blood of the child in red corpuscles, and more especially in hæmoglobin, over that of its mother is extremely important when one considers the question of intra-uterine respiration and metabolism. There can be no doubt that the excess of hæmoglobin, and consequently preponderance in oxygen-carrying power on the part of the blood of the child, must be one of the most important means by which its metabolism is carried on as it is, and yet, although this excess of hæmoglobin has been long known, its importance is not usually drawn attention to in this connection. When one remembers that the child's blood can only be oxidized in an indirect manner through the blood of the mother, and that consequently it is possibly in a comparative state of cyanosis, one can at once see how valuable it must be for the child to have a great quantity of red corpuscles, and especially of

the hæmoglobin, in its blood to compensate for this. And it is interesting to notice that in children with congenital malformations of the heart and cyanosis one also finds this great excess in red corpuscles and hæmoglobin (8), which in this case also is probably compensatory.

After birth, when the child's blood is directly oxygenated by being brought into close relation with the air in the lungs, there does not seem to be any longer a necessity for this excess of hæmoglobin, and so one finds that during the first fortnight of extra-uterine life the amount of hæmoglobin in the blood rapidly decreases. The excess of hæmoglobin and of red corpuscles in the blood of the child *in utero* also shows that the life of the child is to a certain extent parasitic,—*i.e.*, that it has a certain amount of independence. In cases of anæmia, for instance, the blood of the child does not seem necessarily to suffer *pari passu* with that of the mother; but, on the contrary, the child seems to get more than its fair share. As a rule, however, in any two cases the blood of the child of the more anæmic mother would probably contain fewer corpuscles and hæmoglobin than that of the child of the less anæmic mother. These results do not throw so much light on the life-history of the cell-elements of the blood as one might at first be inclined to suppose. The presence of a larger number of red corpuscles in the child's blood is not necessarily a proof that the blood-forming glands are more active in the child. The mere fact that there are more lymphocytes in the blood of the child at birth, and even still more during intra-uterine life, than in that of the adult, is not a proof that the lymphocytes develop into other leucocytes. The age of the organism does not necessarily bear any relation to the age of its individual cells. One cannot, therefore, take for granted that in the fœtus there are a larger proportion of young white corpuscles than in adults; and so, although there are more lymphocytes in the newly-born child, it is not to be taken as proved that these cells (lymphocyte) are young cells. The excess of lymphocytes may be explained in many other ways.

NORTH OF ENGLAND OBSTETRICAL AND GYNÆCOLOGICAL SOCIETY, CHESTER.

Early Diagnosis of Cancer of the Cervix Uteri.—DR. W. J. SINCLAIR, of Manchester, in a paper upon this subject, stated that if, in any given case under examination, the results obtained by palpation and the closest inspection are such as to leave any doubt in the mind of the practitioner as to whether the condition is or is not early cancer of the cervix, the doubt will be invariably cleared up by ascertaining the amount of friability of the tissues. If the suspected portion be thoroughly exposed by a suitable speculum, and the uterus held steady by the volsella, if the disease be malignant a firm scrape with a sharp curette or spoon will enable the examiner to obtain a definite, distinct piece of tissue, larger or smaller according to the extent of the infiltration and consequent friableness of the tissue thus operated upon. If it be not malignant, the firm scrape with the sharp curette will only make the parts bleed, and, at the most, some small thin shred or pellicle of semitranslucent epithelium or of granulation will

be obtained. The difference was strikingly brought out by the speaker by comparing the effects thus produced upon a case of old chronic cervical catarrh with hypertrophy, ectropium, and retention-cysts, with the effects produced by similar forcible application of the spoon to the tissues in the early stage of epithelioma. The existence of this contrast, with its easy application to diagnosis, is of the greatest importance in general practice, inasmuch as chronic cervical catarrh, complicated with the other tissue-changes just mentioned, is almost the only condition met with which is at all likely to be mistaken for early epithelioma of the cervix. In the case of malignant disease the ring of the external os is complete, and the diagnosis by simple inspection would have to depend upon a mere shade, an indescribable difference in the color of the mucous lining and of the discharge at the os in the two cases respectively. A comparison between the results obtained by palpation would not have brought us anything further toward the completion of a differential diagnosis. In both cases there was a certain element of hardness, unevenness, and irregularity in the consistency of the tissues about the external os; in both there appeared to be some hypertrophy of the cervix, but there was nothing, as far as touch was concerned, that would justify one in saying that one case was malignant and the other was not. From certain facts in the clinical history of the malignant case the nature of the disease was suspected and the test of the sharp curette was applied. The instrument cut through from inside the os downward to the vaginal surface of the portio as through a piece of moist cheese, and, although a microscopical examination of the tissues was made, the diagnosis was completed by the effects of the curette, taken in conjunction with the other clinical facts, quite independently of the histology. On extirpation of the uterus there was found to be extensive breaking down of the tissues of the cervix uteri, extending even above the internal os.—*Medical Chronicle*, September, 1895.

UNITED STATES.

American Neurological Association.

Railway Spine.—Dr. F. X. Dercum, of Philadelphia, reported two cases of this affection, with autopsies. In the first case there had been excessive sprain of the muscles of the back and of the trunk generally, with marked spasm of the muscles and tremor, together with increased reflex excitability of the muscles and tendons. In addition, the symptoms so commonly observed in traumatic neurasthenia had been typical, namely, disturbed sleep, startling dreams, sudden awakening with fright, excessive sweating, frequent micturition, occipital headache, tinnitus aurium, marked general weakness, etc. The patient had died from some intercurrent disease. Careful examination of the nervous system had shown no demonstrable lesion. In the second case there had been severe traumatic left brachial neuritis and left brachial monoplegia, with atrophy of the muscles about the left shoulder, severe sprain of the muscles of the back, right hemi-

analgesia extending from the foot up to the level of the nipple, and right hemithermo-anæsthesia extending from the foot up to the level of the false ribs. The man had been exceedingly weak physically, but mentally he had seemed clear and had accepted his situation in a philosophical spirit. He had died suddenly from the rupture of an aortic aneurism. The post-mortem examination of the nervous system had proved negative.

Dr. Joseph Collins, of New York, said that, although the autopsy and subsequent histological investigation had not resulted in unraveling the mystery of the real basis of the traumatic neuroses, the cases were instructive because of the negative findings. He was in the fullest accord with Dr. Dercum as to the futility of attempting to demonstrate the organic basis of these diseases by means of the old methods of investigation, more particularly by any such as required hardening in Müller's fluid for the preparation of specimens. In the first place, this procedure allowed of no cellular stain except with carmine, and this was so inferior to the Nissl stain that there should be no reason for using it; and in the second place, even if it were a good one, the changes that went on in the structures which it stained, from lying for several months in a watery fluid, were such as to negative any conclusions that might be drawn from possible findings.

In one of Dr. Dercum's cases the ponto-bulbar symptoms had been so pronounced—the facial twitchings, the hemiatrophy, the sensory disturbance—that it was extremely likely that some anatomical change had been at the bottom of it. It seemed to him, moreover, that the presence of the large aneurism, which in all probability had been of traumatic origin, would indicate that the changes in these cases were primarily vascular.

Dr. Charles K. Mills, of Philadelphia, looked upon these negative results as being very valuable. The microscopical examination should, however, have included that of the dorsal spinal ganglia.

Dr. Prince said that the paper contained a direct proof of the theory of the traumatic neuroses. These patients suffered from psychical shock and physical shock. He agreed with Dr. Collins as to the method of study of nerve-tissues.

Dr. Edward D. Fisher, of New York, reported two similar cases still under observation. He believed there must be some pathological changes to account for the symptoms in many of these cases.

Dr. Smith Baker, of Utica, N. Y., expressed the opinion that, at the time of the accident, there was a psychical copy formed which perpetuated this as a series of mimicry. A fixation of attention resulted, and might bring about changes in the higher cortical centres.

Dr. L. C. Gray, of New York, thought that the nature of these cases was still very puzzling. The term "hysteria" was objectionable. These railway subjects were, however, not hysterical.

Dr. F. F. Miles, of Baltimore, expressed the opinion that we should cease to record diseases as functional. The protoplasm of the neuron was altered in its activities by shock. Protoplasm had a tenacious memory (as we saw when we had once taught it to make antitoxins) and might repeat

an abnormal process until it was fixed by material change. The mystery was as to why this took place in some cases of shock and not in others, and as to why this memory was perpetuated in the cell.

Dr. Dercum said that he fully realized the imperfection of the method adopted in preparing the specimens, but this had been due to unavoidable circumstances in connection with the autopsy, and not from lack of familiarity with the newer methods.—*New York Medical Journal*, July 6, 1895.

Maine Medical Association.

Pyosalpinx.—Dr. J. F. Thompson, of Portland, in a paper on this subject, said that distension of the tube to the size of a uterus at the third month of pregnancy marked the limit of enlargement before bursting. Decomposition and infection of retention *débris* after miscarriage or abortion had an equal place with gonorrhœa as a causative agent. Preventive treatment by removal of inflammatory conditions in any part of the genital tract was most important. Distension by pus should be relieved by vaginal puncture to anticipate spontaneous rupture. Such treatment is only palliative, and should be followed by complete removal of the diseased organs, with drainage if there has been much oozing or soiling of the peritoneum with escaping pus. Diagnosis from typhoid fever is not to be lost sight of, long-continued fever being strong presumptive evidence of inflammatory action in the tubes. Complete removal of the uterus in these cases by Gordon's method is followed by better results, both local and systemic, than is simple Tait's operation, especially in cases of long-continued suppurative endometritis or marked retrodisplacement of the uterus with endometritis. Cases of briefer duration, or where there is no displacement, may be cured by removal of the appendages, preceded by thorough curetting of the endometrium.

Dr. S. C. Gordon favored hysterectomy in addition to removal of appendages. He had seen tubes resuming their function after early evacuation of pus by vaginal puncture.

Dr. A. P. Dudley, of New York, thought the proper line of work during the next ten years ought to be preventive rather than destructive. Surgery that cannot save anything to the woman but the vagina is poor surgery.

Dr. S. H. Weeks, of Portland, agreed with Dr. Dudley. He would remove ligaments with tubes. He preferred to save the cervix as a support in the pelvic floor. He would leave any part of uterus or tube or ovary which was sound.

Dr. Woods Hutchinson, of Des Moines, Ia., being invited to take part in the discussion, said 85 per cent. of all cases were due to gonorrœhal infection, the remainder to tubercle bacilli.

Dr. Thompson, in closing, expressed his belief that there was more butchery done in the name of conservative surgery than good surgery. The best surgery is that which conserves the health and safety of the woman for the longest time. He thought curettage of a uterus without re-

moval of appendages for these cases would amount to about as much as curetting the rectum to cure an appendicitis.

OREGON STATE MEDICAL SOCIETY.

Retrodisplacements of the Uterus.—DR. ERNEST F. TUCKER, of Portland (*New York Medical Journal*, July 1, 1895), described a procedure which he had been perfecting for the cure of retrodisplacements due to adhesions.

After all the good that could be accomplished by local treatment had been obtained, such as by curing any endometritis, cellulitis, or pelvic peritonitis, or any inflammatory condition of the appendages that could be cured without their removal, the patient was prepared for the operation as carefully as if she were to undergo vaginal hysterectomy. After being anæsthetized, she was placed on her back and an opening made into the peritoneal cavity through the posterior vaginal vault. The finger was then introduced and the adhesions between the uterus and the rectum were broken up; when these were separated the uterus could be readily pushed forward. If there were any bleeding-points, these could be readily ligated, and at the same time the condition of the appendages could easily be made out and, if necessary, any adhesion binding down these organs torn away and the ovaries and tubes freed. The opening into the peritoneal cavity was then closed and the cervix operated on if necessary; after this a tampon of iodoform gauze was placed in the vagina to hold the uterus in position and the operation was completed. The patient was then placed in bed and made to lie on her side as much as possible, to aid in maintaining the uterus in position, although this rule had not been adhered to in the second of the speaker's cases, the uterus maintaining its position perfectly up to the present writing. At a later date, as soon as convenient, the perineum should be restored. The bowels should be kept loose, to prevent straining. The length of time that the supporting tampon should be left in the vagina after the operation would vary with the condition of the uterus. In most cases a few days would be all that was necessary. In performing laparotomy for the removal of diseased appendages, where retrodisplacement with adhesions was present, the result was not permanent because the removal of the appendages defeated the object in view, so far as the position of the uterus was concerned, on account of the contracture of the broad ligaments which followed the removal of the ovaries and tubes, and would have a tendency to displace the uterus anew. After removal of the ovaries and tubes the uterus had to depend for its blood-supply on the uterine arteries alone, the circulation in which was much more readily interfered with than that in the ovarian arteries,—a fact which made displacements in such patients much more difficult to treat. The speaker's cases had so far been successful, and he did not see any theoretical reason why they should not continue so, or why the operation should not prove of value. The procedure had certain advantages over other operations from its extreme simplicity, and again from its removing all pathological conditions without substituting any new ones.

DR. GIESY had found that unless adhesions were broken up the simple repairing of lacerations did not cure displacements. He agreed that if a cure was to be attained, the cause must be removed.

DR. JOSEPHI thought that there would be a tendency, after the breaking up of the adhesions, where the raw surfaces were left, for them to adhere again.

DR. J. A. FULTON, of Astoria, had been doing Alexander's operation for the correction of certain displacements, but was about to abandon it because the results had not been good enough. It appeared to him that the operation suggested by Dr. Tucker offered several advantages. The vaginal route was being adopted by many, and it certainly was a step in the right direction.

Dr. H. R. HOLMES, of Portland, did not indorse the operation or the view that it had advantages over ventral fixation or other known methods.

DR. TUCKER said that there was no danger of the surfaces becoming attached again, as such adherence only occurred between diseased parts. The operation was never to be done while there was any peritonitis present. When the adhesions had been broken up and the uterus put in position, the separated tissues were not apposed; so that on that ground no re-adhesion could take place. Alexander's operation had always seemed to him to be a subterfuge, substituting one abnormal condition for another.

Selections from Reports of Members of the Annual's Staff of Correspondents.

Holland.

DR. A. MIJNLIEFF,
REDACTEUR CORRESPONDENT FÜR GEBURTSHÜLFE UND PUERPERAL KRANKHEITEN.

Alle Bücher, Thesen, Separat ab drücke, etc., über obengenannte Gegenstände in hollandische Sprache erscheinend, solten Herrn

DR. MIJNLIEFF,
Breukelen,
Holland.

zugesandt werden.

Puerperal Involution.—C. K. BROERS, in his inaugural thesis at the University of Leyden, considered the subject of puerperal involution of the uterine muscles, basing his conclusions on careful study of the rabbit at various parts of the post-partum period. He expressed the opinion that at the beginning of the puerperium the diminution in size of the uterine muscle is to be attributed to a glycogenic effusion of the hypertrophied muscular fibres, with a resorption of the œdematous intermuscular fibrous tissue. Probably the glycogen, having undergone a chemical modification, is transported by the lymphatics. This effusion of glycogen, which begins in the first hours after delivery, is the sole factor in the diminution of the musculature,—a diminution which follows a progressive course until the end of the first day, when a new factor is added. Small fat-globules collect in the muscular cells, and little by little increase in size and become confluent. They leave the cells and are temporarily deposited in the inter-

muscular fibres, to be finally expelled on the fifth day. Their expulsion causes a considerable decrease in the size of the muscles, which by the end of a week and a half have reached the average normal dimensions. The process in no way implies a destruction of the muscular fibre, the fat which is formed being transported by the lymphatics and vessels so slowly that at the end of nearly five weeks it has not entirely disappeared. The same process also goes on in the coats of the arteries, the lumen of which sometimes undergoes considerable contraction,—so much so that an artery may sometimes be entirely closed from proliferation of its internal coat.

Retention of the Placenta after Abortion.—T. G. EVERS criticises the expectant plan in cases of this nature, since it offers no security against possible infection, and declares that the use of the curette, though not entirely free from danger, is, nevertheless, the most efficient method of treating retention of the placenta. Swabbing out he also regards as inferior to curetting, since in ordinary practice perfect asepsis is only possible by sterilization.

Detachment of the Placenta during Pregnancy.—H. G. PLUIM relates, in the same journal, a case in which he diagnosed detachment of the placenta eleven days before term in a VII-para. The diagnosis was confirmed by the simultaneous expulsion of the dead fœtus and the after-birth, followed by a mass of dark-colored clots. G. C. NIJHOFF also describes a case in a primipara, and J. A. NORNBACH, in his inaugural thesis, adds to the twenty-five instances recorded in literature a new case observed by himself in the obstetrical clinic of Trøub.

Sweden.

DR. F. EKLUND,
Brefväxlande Medarbetare för den
SVENSK MEDICINSK LITTERATUR.

Af alla i Sverge utkommande medicinska tidskrifter, bocker, afhandligar, monographier a. s. v. torde ett exemplar benäget öfversändas till

DR. ABRAHAM FREDRIK EKLUND,
Sibyllegatan, 8 A,
Stockholm.

Scarlet Fever.—CARLSSON, in the "Appendix to the Annual Report of the Stockholm Board of Health," gives some notes on scarlet fever in St. Catherine's Hospital in that city, based on a study of 4000 cases. Of these 3106 (77.6 per cent.) were under the age of 11 years, the disease being most frequent at the age of 4 years (474 cases). Sixteen per cent. were between the ages of 11 and 20 years, 5 per cent. between 21 and 30 years, 1.15 per cent. between 31 and 40 years, and 0.125 per cent. over 40 years; 1960 were males and 2040 females. Of 8609 cases of scarlatina occurring in Stockholm from 1880 to 1891, 2508 occurred between December and February, 1888 between March and May, 1585 between June and August, and 2628 between September and November. As to the period of incubation, though subject to great variations, it was, as a rule, not less than five days and not greater than ten days. Of the 4000 cases at St. Catherine's Hospital, not less than 1995 (50 per cent.) showed pseudomembrane in the fauces, appearing from the first to the fifth day in 1965 cases, from the sixth to the tenth day in 21 cases, from the eleventh to the fifteenth day in 8

cases, and between the thirty-fifth and the fortieth day in 1 case. Patients under 1 year of age were the most frequently attacked with diphtheria, 975 being males and 1020 females. Croup was noted in 53 cases and otitis media in 250 males and 229 females, nearly all of these being from 2 to 6 years old and nearly all suffering also from diphtheria. However, only two or three patients showed any high degree of dullness of hearing. Albuminuria occurring between the first and fifth day was observed in 248 cases, 78 of which developed nephritis later on,—a comparatively small number out of the 988 cases of nephritis, 171 of which became chronic. Bronchitis complicated 282 cases and broncho-pneumonia 147 cases, children under 5 years being most exposed. There were 34 cases of exudative pleurisy, 6 only being purulent; 6 cases of pericarditis and 4 or 5 cases of endocarditis were recorded, but in several post-mortem examinations alterations in the cardiac muscle, myocarditis, fatty degeneration, etc., were found. Rheumatism occurred in 256 cases and incipient noma in 1 case. A 3-year-old girl died on the thirtieth day from diphtheritic colitis. Diarrhœa was observed in 236 cases, mostly between 2 and 5 years of age; 299 developed lymphadenitis colli, 118 cases being suppurative. A few cases were complicated by meningitis due to aural disease. The mortality was 754 (18.8 per cent.), 731 being children and 23 adults,—409 males and 345 females. The mortality in the *foudroyant* cases was only 3.45 per cent.

Clinical Notes.

Varicose Ulcers.—Du Castel (*L'Union Méd.*, July 17, 1895), apropos of the relation between varicose ulcers and the nervous system, remarks that, in a certain number of cases of ulceration declared to be varicose, the rôle of the varices and of the imperfect venous circulation is insignificant and sometimes of no importance whatever, the symptoms appearing rather to depend upon disturbance of innervation in the member. The subjects are generally young and the ulcerations are preceded by recurrent bullæ, are besides not very deep, and usually cicatrize easily. There seems to be an asthenia of the lower limbs, leading to a variety of ulcerating trophoneurotic pemphigus. In such cases a general treatment should be instituted in addition to the ordinary local treatment of the ulcers. The condition of the nervous system should be modified by iodide of potassium, strychnine, arsenic, prolonged baths, electricity, and, if necessary, a sojourn at some mineral springs.

Wounds of the Chest.—Folet, of Lille (*Bull. Méd. du Nord*, May 10, 1895), cites two interesting cases of penetrating wounds of the chest by revolver-balls. In the first case the ball penetrated the lung and became encysted without the slightest accident. In the second case the bullet entered the right side of the thorax above the liver and re-appeared under the skin. It was easily extracted, but the patient showed serious symp-

toms leading to the diagnosis of hæmopneumothorax with extensive subcutaneous emphysema. There was no hæmoptysis. The effusion became suppurative and cure was only obtained at the end of several weeks by pleurotomy with costal resection and repeated antiseptic irrigations. Folet concludes, from his experience in these two cases, that the expectant plan is indicated in the beginning, the local and general condition being carefully watched. A gaseous, fluid effusion does not necessarily call for intervention, as it may disappear without causing any complication. Hyperpyrexia, dyspnœa, and small pulse are the symptoms which call for opening of the chest.

Cerebral Uræmia.—Rendu (*Jour. de Méd. et de Chir. Prat.*, July 10, 1895) believes that two factors should be considered in cerebral uræmia, the one being an undoubted and dominating toxic element which is due to faulty elimination of the *débris* of the organism by the diseased kidney. The other factor, too much neglected in the theories of the present day, is a mechanical one, namely, cerebral œdema, the localization of which in the motor zones may give rise to convulsions, either general or limited to one side, to one member, or even to several muscles of the face. In other cases the uræmia assumes an apoplectic form, while in others it is hemiplegic, both depending on cerebral œdema. The author regards it as probable that many instances of hemiplegia attributed to hæmorrhage or softening are more likely due to uræmia. In the post-mortem examination of a number of cases of hemiplegia no lesion can be found, but the explanation is facilitated by the theory of an area of œdema which has disappeared at the moment of death.

Early Diagnosis of Tuberculosis.—Grancher (*Le Bulletin Médical*, July 10, 1895) establishes an early diagnosis in tuberculosis by observing the roughness of inspiration. When this symptom is present it is sufficient, but when it is associated with functional signs the diagnosis is confirmed. It is certain that simple bronchitis causes an alteration in physiological respiration, lasting for some time; a slight irritation of the mucous membrane of the lesser bronchi, a slight rugosity of the pleura will sometimes cause persistent respiratory murmurs. When, however, inspiratory roughness is found to be persistent and localized at the apex, tuberculosis is to be thought of; and if there is anything in the general condition, such as a sensation of fatigue or loss of flesh, immediate treatment should be instituted.

Heart Disease in Pregnancy.—Rivière, of Bordeaux, claims that in a case of pregnancy with cardiac disease sole thought should not be given to the heart; by watching and treating the kidneys, the skin, the intestines, and the lungs, the state of the heart may be relieved, asphyxia and intoxication be prevented, and time gained; and even if the mother cannot be saved, the child will thus have the best possible chance for life. (*Gaz. Heb. de Bordeaux*, June 30, 1895.) According to this author the infant is of real importance, and when the woman is affected with an incurable cardiac trouble the pregnancy should be allowed to go on as long as possible, even

to term, on account of the great risk at the moment of delivery, whether spontaneous or induced. Artificial labor is rarely indicated in a pregnant woman in whom the cardiac symptoms have ended or are about to end in asystole. Venesection acts more favorably and rapidly, aided by oxygen to stimulate the lungs, milk for the kidneys, purgatives and intestinal disinfectants. Chloroform may safely be given at the end of the period of dilatation and during expulsion, which must be artificial in order to hasten delivery.

Purulent Ophthalmia in Pneumonia.—HAUSHALTER and VILLER, of Paris (*Gaz. Hebdomadaire*, July 6, 1895), describe a case of purulent ophthalmia with pneumococci in an alcoholic patient suffering from influenzal pneumonia. Unilateral ocular pain appeared on the fourth day, and intense iritis on the fifth day. Four days later pus was removed by incision from the anterior chamber and found to contain the diplococcus of Fraenkel, Death occurred on the fourteenth day, ten days after the appearance of ocular symptoms. Post-mortem examination revealed an area of pneumonia going on to gray hepatization, a phlegmon of the eye, and a few patches of meningitis in the convexity. The pneumococcus was found in a pure state in all these lesions, and after inoculation into mice was discovered in the spleen of the animals.

Sarcoma of the Small Intestine.—PIC (*Revue de Méd.*, December, 1894) considers successively the supra-, peri-, and sub- vaterian forms of primary sarcoma of the small intestine, cites twelve cases, and quotes the statement of Köhler, that, in three-fourths of the cases of cancer of the small intestine, the seat is the duodenum.

J. BRAULT, of Algiers (*Arch. Gén. de Méd.*, July, 1895), in reporting a case of sarcoma of the ileum, remarks upon the insidious progress of the disease and the absence of signs of obstruction or of hæmorrhage; the patients become emaciated and weakened without suffering from any pain or marked disturbance of digestion, before the tumor can be made out either by patient or physician. When the growth acquires a certain size it may be mistaken for a tumor of the mesentery.

Parosteal Lipoma.—FREDERICK PAGE, of Newcastle-on-Tyne (*Lancet*, July 20, 1895), adds another case of parosteal lipoma to the seven cases recorded by Bland Sutton ("Tumors," London). The growth, which had been developing for four years on the minor side of the lower end of the right thigh in a woman 45 years of age, was as large as a goose-egg, encapsulated, and so closely connected with the periosteum that it could not be separated from it. The superficial veins over it were enlarged, and the swelling so closely simulated a periosteal sarcoma that it might have led to amputation of the limb rather than removal of the growth. The author knows of only one other example of parosteal lipoma of the femur,—that reported by D'Arcy Power (*Transactions of the Pathological Society*, London).

Sudden Death in Scarlatina.—DUCLOS calls attention to sudden death occurring on the third or fourth day of the eruptive period of scarlatina.

(*Jour. des Praticiens*, July 21, 1895.) This unexpected termination is preceded by no premonitory symptoms, no external or internal cause can be evoked, there are no contractures or convulsions, and autopsy shows no lesions which could account for it. The clinical picture is always the same,—sudden and unexpected loss of consciousness, frequent pulse, dyspnœa, persistence of the eruption, intense heat, and death in a few hours. The author is inclined to attribute the fatal issue to an excess of the toxins of scarlatina, either from overproduction or defective elimination.

Urine in Epilepsy.—OBREJA (*Presse Méd. Roumaine*, July 7, 1895) finds that the evening preceding an attack of epilepsy the toxicity of the urine is greatly diminished; but immediately after the attack it increases markedly, to diminish progressively afterward. In the case of a criminal simulating epilepsy, he was able to detect the fraud by examination of the normal constituents of the urine. He also states that the approach of a period of excitement in melancholia or periodic insanity may be prognosticated by a diminution of the urinary toxicity.

Fatal Retropharyngeal Abscess.—PLATOT and VARIOT (*Jour. de clin. et de thér. infantile*, July, 11, 1895) note a case of retropharyngeal abscess, in an infant of 14 months, in which death occurred suddenly at the moment of incision. The fatal result was not due to the invasion of the air-passages by the pus, and could only be explained by a reflex syncope.

Bothriocephalus-Anæmia.—The anæmia due to the *Bothriocephalus latus* has been carefully studied by OSSIAN SCHAUMAN. ("Zur Kenntniss der sogenannten Bothriocephalus-Anæmie." Von Dr. Ossian Schauman. Helsingfors: Weilin & Göös, 1894.) The author describes seventy-one cases of this form of the disease, which is characterized by great pallor of the skin and mucous membranes, an expression of fatigue and moderate fever, though the temperature sometimes exceeds 40° C. and is in relation with the degree of anæmia. He has observed a subnormal temperature before death in fatal cases. The bones are often sensitive to pressure and the strength diminished; headache is almost constant, listlessness and vertigo and insomnia frequent; the bulbar conjunctiva is yellow. Retinal hæmorrhage occurs in half the cases when the red cells number 400,000, and in some instances the author observed deafness and contractions of the facial muscles. Respiration is generally normal, though there was hæmoptysis in one of his cases. Palpitation of the heart is frequent, with anæmic murmurs and increased arterial beats, while the pulse varies in frequency. Hæmorrhage of the buccal mucous membrane and gums, anorexia, and dyspepsia are also symptoms, and Schauman believes that the stomach discharges its contents more rapidly than in the normal state, and that albuminoids are scarcely digested in it. Diarrhœa is frequent, and the eggs of the bothriocephalus may be found in the stools. The quantity of urine is variable, and the author noted indican, urobilin in eight cases, and biliary pigment in one case. The clinical picture, it will thus be seen, closely resembles that of the classical pernicious anæmia.

Examination of the blood in Schauman's cases showed the specific gravity to be greatly diminished and the number of red cells to be altered, varying from 2,150,000 to 395,000 in men and 1,968,000 to 798,000 in women. The disease begins slowly and insidiously, by disturbance of digestion, followed by diarrhœa and constipation. The duration is from one month to ten years, and in the latter case there are periods of relative temporary amelioration. Recovery may be brought about by suitable treatment, but the author has observed that in such cases the hydrochloric acid remains absent from the gastric juice. When death occurs, it does so in coma, with lowered temperature and accelerated pulse.

The anatomical alterations noted are: hæmorrhage of the various organs, serous and mucous membranes; the heart is normal in size, but soft and in a state of fatty degeneration; the aorta is normal, the spleen and liver not hypertrophied. There is no special thinning of the intestine nor glandular atrophy as in pernicious anæmia, and the nematoid parasite is present. The bone-marrow is red and contains red nuclear cells. The eggs of the parasite in the stools are almost pathognomonic, since it is rarely that they are met with in pernicious anæmia due to any other cause. The differential diagnosis must be made between chlorosis and cancer, and there is a possibility of confounding the affection with endocarditis, meningitis, typhoid fever, catarrhal icterus, or diseases of the spinal cord. The prognosis is good when the number of red blood-cells exceeds one million, but it is not entirely unfavorable until they fall to half that number. An organic disease is always to be dreaded as a complication. Treatment naturally consists in bringing about the elimination of the parasite, recovery usually ensuing in from six to eight weeks.

In a case seen by Askanazy (*Zeit. für klin. Med.*, Bd. xxiii, H. 5 und 6) the anæmia was most pronounced, the patient, a man 58 years old, having been affected with intestinal parasites from the age of 15 years. In spite of all treatment the head of the tænia had never been expelled. On his entrance into the hospital he was given a powerful vermifuge, and among the large quantity of parasites voided sixty-seven heads of the bothriocephalus were recognized.

Castration in Prostatic Hypertrophy.—Dr. J. William White, of Philadelphia, gives a summary of 111 cases treated by this method, reviews the objections urged against it, and brings evidence to prove its value (*Annals of Surgery*, July, 1895). The function of the testis, like that of the ovary, is twofold—the reproduction of the species and the development and preservation of the second sexual characteristics of the individual. The need for the exercise of the latter function ceases when full adult life is reached, but it is possible, the author holds, that the activity of the testis and ovary in this respect does not disappear coincidently, and that hypertrophy of closely-allied organs such as these is the result of this misdirected energy. The theoretical objections urged against double castration have been fully negatived by clinical experience, which shows that rapid atrophy of the enlarged prostate follows the operation in a very large proportion of cases—about 87.2 per cent.—and that disappearance or consider-

able diminution of long-standing cystitis occurs in about half the number of patients thus treated. Moreover, amelioration of the most troublesome symptoms is produced in 83 per cent. of the cases; and a return to local conditions not very far removed from those that are normal may be expected in a considerable number—46.4 per cent. Of the 111 cases tabulated by the author 18 were fatal. But of these, it is held, there are 13 that may fairly be excluded in an attempt to ascertain the legitimate mortality in patients operated on under surgically favorable conditions,—that is to say, before the actual onset of uræmia, or before the kidneys have become disorganized through backward pressure and consequent infection. Even of the desperate cases which make up this series of deaths, in many—75 per cent.—shrinkage of the prostate and improvement of the symptoms followed the operation. Comparison with other operative procedures seems to the author to justify the conclusion that, apart from sentimental objections, castration offers a better prospect of permanent success than any other method of treatment. The value of this operation is further enhanced by its smaller mortality as compared with that of prostatectomy; by the absence of any risk of permanent fistulæ, perineal or suprapubic; by the ease and quickness with which it can be performed, and by the possibility of avoiding anæsthetics, which in these cases are in themselves dangerous. The evidence as to the efficacy of unilateral castration is at present contradictory. In two cases, at least, this operation has resulted in a very marked improvement of symptoms. The author's experiments on dogs have shown, in nearly every case in which the vas deferens was tied or divided on both sides, that without much change in the testicles commencing atrophy and considerable loss of weight in the prostate resulted. The absence of corresponding testicular changes, however, rendered these results somewhat anomalous. Ligature of the vascular constituents of the cord or of the whole cord will produce atrophy of the prostate, but only after it has caused disorganization of the testis.

Isnardi (*Centralbl. für Chir.*, No. 28, 1895) reports a case of enlarged prostate, with serious and intractable urinary trouble, in a patient aged 71, which was successfully treated by double ligature and division of the vas deferens on both sides. The incontinence ceased after the operation, the urine became quite clear, and the enlarged prostate diminished so much in size that it could no longer be felt on rectal examination. The epididymis on each side became smaller and harder after the operation, and the volume of each testis was reduced by one-half, the condition of these parts resembling that consequent on chronic gonorrhœal epididymitis.

The method successfully adopted by Dr. Eugene Fuller (*Journ. Cut. and Gen. Urin. Dis.*, June, 1895) in six cases of enlarged prostate was briefly stated as follows: 1. The bladder was opened above the pubes, the left forefinger passed in and the vesical orifice of the urethra felt. 2. A pair of rough serrated-edged scissors, guided by the finger, was made to incise the bladder-wall from the orifice of the urethra backward for an inch and a half. 3. A forefinger (whichever the operator found most convenient) was then passed through the incision in the bladder, and made

to enucleate the prostatic obstruction "*en masse* or piece by piece, as the case may be." The enucleation was assisted by counter-pressure made on the perineum by the unoccupied hand. This enucleation can be easily and speedily accomplished in this manner. 4. A perineal section was then made and a large soft-rubber tube passed through the incision in the bladder, and, after irrigation of the latter with hot water, the suprapubic incision in the bladder-wall closed by a double row of sutures. The hæmorrhage was always of little consequence. Fuller's first case was operated on in May, 1894, and the patient could, at the time of writing, pass his urine naturally at proper intervals, emptying the bladder at each act.

The Auscultation of Joints.—Sir Benjamin Ward Richardson, who has made a practical study of the subject, states that auscultation is quite as useful in joint affections as it is in affections of the lungs, but that it requires to be learned in its details before it can be fully applied. (*Asclepiad*, 3d quarter, 1894–95.) Joints that are healthy must be auscultated as well as joints that are diseased, and the latter, in turn, must be auscultated and learned according to the kind of diseased condition that may be present. Distinction must also be made between the sounds that arise from the friction of bones in their sockets and upon each other. For conducting this kind of examination the double stethoscope is the best, but he sometimes uses the simple differential stethoscope, which consists of two single-mouthed tubes quite separate, the ear-pieces of which can be adapted to each ear. The mouth-piece should not be large—three-quarters of an inch in diameter is sufficient—and it is advisable to have the mouth-piece covered at its edge with India rubber, so as to avoid external friction. If the double stethoscope be not at hand the ordinary wooden instrument will suffice; but the advantage of the double one is that it enables the operator to manipulate the joint and bend it without the aid of an assistant, although the latter is always of service.

When a joint is quite healthy and the person auscultated is young there is practically no sound or movement whatever. No sound will be heard, except a very gentle soft friction sound, if the movement be made in such a manner as to bring the end of the movable bone with some force into collision with the joint or bone that opposes it in the socket. When a sound is produced it may be called a cushioned sound, and it ceases the moment the action that produced it is slowly carried out without pressure. A very little derangement within the joint itself—less than a friction that produces impediment of motion, much less than an impediment that gives rise to pain—leads, however, to sounds that are distinguishable, the abnormal sounds increasing in degree as the impediment within the joint is intensified or modified. There are, at least, five modifications of joint sounds; they may be defined as: simple dry friction sound; dry grating sound; coarse grating sound; moist crepitant sound; and coarse crepitant sound.

Recent Suggestions in Therapeutics.

Asiatic Cholera.—*Distilled water*, 110 grammes (3½ fluidounces); *chloroform*, 1 gramme (15½ minims); *alcohol*, 8 grammes (2 fluidrachms); *acetate of ammonium*, 10 grammes (2½ drachms); *syrup of morphine hydrochlorate*, 40 grammes (1¼ fluidounces). This potion gave the best results in the author's hands during the epidemics of cholera in Damas in 1875, in the French-Indian colonies in 1876, and in Cochin China in 1882. It is also serviceable in choleriform diarrhœa. (DESPREZ, *Le Nord Méd.*, August 1, 1895.)

Corneal Ulcer.—Cases of intractable corneal ulceration which have long resisted the usual methods of treatment quickly improve under the use of *glycerite of tannin* and *carbolic acid* prepared according to the following formula: ℞ *Carbolic acid*, 15 grains (1 gramme); *tannic acid*, 30 grains (2 grammes); *glycerin*, 1 drachm (4 grammes). M. Carefully cleanse the eye with warm sterilized water strongly impregnated with *boric acid*, introduce a few drops of weak *cocaine solution* to annul pain, and, after a wait of five minutes, freely touch the ulcer with the *glycerite* by means of a fine camel's hair pencil. Repeat twice or thrice daily for the first few days and then gradually discontinue as healing progresses. In conjunction with this treatment it is well to maintain the usual instillation of *atropine*. Unpleasant reaction never occurs. (A. L. HALL, *Medical Record*, August 31, 1895.)

Digitalis in Pneumonia.—NÆGELI-AKERBLOM (*Cent. f. inn. Med.*, August 10, 1895) regards *digitalis* as the most valuable agent in acute pneumonia when used in large doses. The drug, according to his investigations, causes hyperleucocytosis, both in man and animals. He advises hydrotherapeutic measures in connection with the *digitalis*.

Gonorrhœa.—℞ *Hydrarg. chlor. corros.*, ⅛ grain (0.01 gramme); *zinci sulphocarbolat.*, ½ drachm (2 grammes); *acid. boric.*, 2 drachms (8 grammes); *liq. hydrogen peroxide*, 6 ounces (186 grammes). M. Sig.: Use as injection. If the urethra be very irritable add also from 18 to 24 minims (1.17 to 1.5 grammes) of the watery *extract of opium*. (W. W. KEEN, *College and Clinical Record*, August, 1895.)

Headache.—DR. C. C. CROLLY, of Pleasantville, N. Y. (*Pharmaceutical Era*, July 4, 1895), treats headaches as follows: One tablespoonful of *extract of malt* (with a few drops of dilute *hydrochloric acid*, to stop fermentation), after meals. This will digest the starchy food. Five to fifteen drops of fluid extract *cascara sagrada*, if constipation is present,—just enough for one evacuation. Half to one teaspoonful of *phosphate of soda* three times a day. This can be continued indefinitely, without danger, and is more successful than salicylic acid. When phosphate of sodium is taken internally there are formed in the urine, while it is descending through the lumen of the uriniferous tubules, by the chemical union of the uric acid with the salt and the decomposition of

Headache (*continued*).

the two, an acid urate of sodium and an acid phosphate, the dihydrogen phosphate, and in this way the patient gets rid of his rheumatism, his headache, neuralgia, or other attacks dependent upon too great a quantity of uric acid.

Infantile Diarrhœa.—LOUIS FISCHER, of New York (*Medical Record*, July 13, 1895), adopts the following plan in cases of gastro-intestinal catarrh due to the combined effects of extreme heat and improper feeding: Irrigation of the stomach and bowels, flushing the colon and rectum until the water returns clear; warm bath, gradually cooled from 90° to 70° F. (32.2° to 21.1° C.), lasting five minutes and renewed every few hours if necessary, followed by an ice-bag on top of the head, the patient being kept in as cool a room as possible. No milk, unless for a nursling, when the breast is discontinued at least one-half a day, to give the stomach rest; *beta-naphthol-bismuth* in doses of 5 to 10 grains (0.32 to 0.65 gramme), for a child of one year, every two, three, or four hours, according to the case; if vomiting persist, rectal feeding and administration of drug in suppository, doubling the dose; no *alcohol*, if possible; cold sponging to check perspiration, using *bay-rum* or equal parts of *alcohol* and *water*.

The following treatment is often employed by DR. J. P. CROZER GRIFFITH after the bowel is relieved of the irritating material by a dose of *castor-oil* or *calomel: Phenyl salicylate*, 1 drachm (4 grammes); *bismuth salicylate*, 3 drachms (12 grammes); *oil of gaultheria*, 12 minims (0.78 gramme); *chalk mixture* to make 3 fluidounces (93 grammes). M. Dose: 2 fluidrachms (8 grammes) every two hours. *Opium* may be added if there is much pain. (*Philadelphia Polyclinic*, August 24, 1895.)

Intermittent Fever.—AUFRECHT (*Ther. Monatshefte*, July, 1895) having found, in common with many other authors, that tablets of *quinine* frequently pass through the digestive tract without being absorbed, advocates the use of neutral *tannate of quinine* for prolonged use. It has scarcely any taste, and, as it contains three times less quinine than the hydrochlorate, larger doses must be given. He has found the following formula very efficacious in inveterate cases: ℞ *Arsenious acid*, 0.05 gramme ($\frac{7}{8}$ grain); *hydrochlorate of quinine*, 2 grammes (31 grains); *glycyrrhiza-powder*, 3 grammes (46 grains); *glycyrrhiza-juice*, q. s. to make 30 pills. Two pills three times a day.

Sycosiform Eczema of the Lower Lip.—*Styrax*, 5 grammes ($1\frac{1}{4}$ drachms); *oil of sweet almonds*, 15 grammes ($3\frac{3}{4}$ fluidrachms); *precipitated sulphur*, 0.50 gramme ($7\frac{3}{4}$ grains). (BROCQ, *Jour. de Méd. et de Chir. Prat.*, September 10, 1895.)

Test for Sugar in Urine.—Dissolve 27 grains (1.75 grammes) of *cupric sulphate* (C. P.) in 8 drachms (12 grammes) of pure *glycerin* and $2\frac{1}{2}$ drachms (10 grammes) of *distilled water*, heating gently to facilitate solution. When cold add *liquor potassæ* to make 4 ounces (125

grammes) and mix thoroughly. Pour 1 drachm (4 grammes) of the solution into a test-tube and boil gently over a spirit-flame. Add 2 or 3 drops of a saturated solution of chemically-pure *tartaric acid* in *distilled water* and boil again. Now add the suspected urine slowly drop by drop, boiling and shaking the test solution between each drop until reduction takes place, or until 8 drops of urine have been added. If no change follow the addition of this amount, sugar is not present. If one part of sugar in a thousand of urine be present, a yellowish or reddish, or sometimes greenish-gray deposit of suboxide will be seen, marked and unmistakable, the reaction deepening when the solution is allowed to stand. The addition of a single drop of urine will promptly develop the reaction; 3 drops give a marked reaction when 2 grains (0.13 gramme) to the ounce (31 grammes) are present, and 4 drops will detect 1 grain (0.065 gramme) to the ounce (31 grammes). More than 8 drops should not be used, as that amount never fails to give a marked reaction when ½ grain (0.03 gramme) or more of sugar to the ounce (31 grammes) is present, and smaller traces than this are of no interest to the practitioner. (A. R. ELLIOTT, Chicago, *New York Medical Journal*, July 27, 1895.)

Typhoid Fever in Elderly Persons.—A. BOLOGNESI, of Paris, discusses the treatment of typhoid fever in patients over 40 years of age, in whom the disease is especially dangerous. (*Bull. Gén. de Thér.*, June 30, 1895.) He regards the bath as the only efficacious method in these cases, and begins by giving a bath of 18° to 20° C. (64° to 68° F.) every three hours, each lasting from twelve to fifteen minutes, with cold affusions to the bulb, in the beginning, the middle, and at the end of each bath. If the heart, lungs, kidneys, or brain be compromised, he gives baths of 18° C. (64° F.) every two hours, lasting from eight to ten minutes, with continuous affusions to the nape of the neck, an ice-bladder on the heart and head, and ice-compresses on the thorax. This he continues until all symptoms of danger are pased, when he gives the baths every three hours, diminishing the number progressively until complete apyrexia is assured, the digestive organs are in good condition, and convalescence is entered upon.

Varicose Veins.—G. PERTHES (*Deutsche med. Woch.*, No. 16, 1895) used Trendelenburg's method of ligature of the saphenous vein in the upper portion of the thigh in 41 cases of varicose veins, 32 definite recoveries being obtained. Several relapses occurred through the vein becoming permeable soon after ligature, and the author from this fact recommends resection of a few centimetres of the vessel.

FAISST (*Beit zur klin. Chir.*, vol. xii, No. 1) reports 25 cases treated in the clinic at Tübingen by this method; of these, 11 were seen at the end of six months and all showed the good effects of the operation as regards the disappearance of pain and discomfort. Cure had been maintained for two years in 2 cases, from one to two years in 7, and less than a year in 3; but in only 2 cases had the varices entirely disappeared.

Varicose Veins (*continued*).

Delore, of Lyons (*Nice Méd.*, April, 1895), gives the statistics of 164 cases of varices treated without a single failure by means of injections of an aqueous solution containing 1 part of *iodine* and 9 parts of *tannin*, marking 18° Baumé. He injects 8 drops of this solution, by means of a Pravaz syringe, into the orifice of a short cannula inserted into one of the principal varicose confluents. During the operation a rubber tube is placed at the root of the thigh. The patient stands during the injection, which is given without anæsthesia, and is repeated when necessary. The veins are then compressed ten centimetres above and below the puncture, the limb is wrapped in boric-acid cotton, and the patient made to lie down and to keep rigorously in this position. An hypertrophic phlebitis is thus brought on, with thickening of the venous walls and consequent resistance to dilatation. Delore declares the possibility of embolism to be purely theoretical, and not borne out by facts.

Monographs Received.

The editor acknowledges, with thanks, the receipt of the following monographs:—

Ricerche Sperimentali sulla Fisio-patologia dei Nervi Laringei Inferiori, per **A. Trifiletti**, Napoli, 1895.——The Treatment of Laryngeal Tuberculosis, by **Robert Levy**, Denver, Col., 1895.——The Possibility of Obtaining Marked Improvement in the Treatment of Deafness, by **M. A. Goldstein**, Saint Louis, Mo., 1895.——On Movable Kidney, by **Geo. Ben. Johnston**, Richmond, Va., 1895.——Report of Two Cases of Crushing Injury to the Arm, by **E. J. Mellish**, Chicago, 1895.——A Practical, Low-Priced Device to Secure the Trendelenburg Posture, by **William A. Edwards**, San Diego, Cal., 1895.——Perforation in Enteric Fever, its Surgical Treatment, by **Frederick Holme Wiggin**, New York City, 1895.——Exfoliation of the Cochlea, Vestibule, and Semicircular Canals, by **M. A Goldstein**, Saint Louis, Mo., 1895.——A Case of Carcinoma of the Parturient Uterus, by **George H. Noble**, Atlanta, Ga., 1894.——Imperforation of the Rectum, by **Geo. Ben. Johnston**, Richmond, Va.——Annual Announcement, Michigan College of Medicine and Surgery, Detroit, 1895-96.——A Method for Resuscitation from Electric Shock, by **P. J. Gibbons**, Syracuse, N. Y., 1895.——Lateral Lithotomy for the Removal of a Wire Nail, by **Z. J. Lusk**, Warsaw, N. Y., 1895.——A Report of the Abdominal Sections in the Gynecological Department of Mercy Hospital, by **Hubert A. Royster**, Pittsburgh, Pa., 1894.——Remarks on the Treatment of Inevitable Abortion, by **Chas. P. Noble**, Philadelphia, 1894.——The Diagnosis of Pregnancy During the First Three Months, by **Chas. P. Noble**, Philadelphia, 1894.——The Murphy Button, by **Aug. Schachner**, Louisville, Ky., 1895.——A Case of Didelphic Uterus with Lateral Hematocolpos, Hematometra, and Hematosalpinx, by **X. O. Werder**, Pittsburgh, Pa., 1894.——Calomel, by **W. Blair Stewart**, Atlantic City, N. J., 1895.——Report of Cases of Brain Lesions, by **J. T. Eskridge**, Denver, Col., 1895.——Chronic Tuberculosis, by **E. E. Axtell**, Denver, Col., 1895.——A New Operating Outfit, by **Aug. Schachner**, Louisville, Ky., 1895.——Cirrhosis of the Liver in Childhood, by **Wm. A. Edwards**, San Diego, Cal., and **Wm. M. Gray**, Washington, D. C., 1895.——Suprapubic Cystotomy for Calculus of the Bladder, by **A. E. Meisenbach**, Saint Louis, Mo., 1895.——Nuovo Apparecchio d'Intubazione Laringea semplificato, per **F. Egidi**, Roma, 1895.——Medical Terminology, by **P. J. McCourt**, New York, 1895.——Traumatic Cyst of the Brain from an Injury Received Twenty-five Years Before, by **J. T. Eskridge** and **F. F. McNaught**, Denver, Col., 1895.——Abdominal Section in Ectopic Gestation, by **X. O. Werder**, Pittsburgh, 1894.——Civil Service Reform in State Institutions—Reorganization of the Medical Staff, by **Boerne Bettman**, Chicago, 1895.——Circular Insanity, by **Wm. F. Drewry**, Petersburg, Va. 1895.——Afonia e Sordità isterica, per **A. Trifiletti**, Torino, 1895.——Strabismus as a Symptom, its Causes and its Practical Management, by **Leartus Connor**, Detroit, Mich., 1895.——The Dilator in Diseases of the Air-Passages and the Ear, by **Seth Scott Bishop**, Chicago, 1895.——Double Athetosis, by **Wm. F. Drewry**, Petersburg, Va., 1895.——Cystic Tumors of the Vaginal Vault, by **Fredk. Holme Wiggin**, New York City, 1895.——The Treatment of Chronic Endometritis, by **X. O. Werder**, Pittsburgh, Pa., 1895.——Address on the Founding of the Illinois Hospital, by **Seth Scott Bishop**, Chicago, 1895.——Cœliotomy for Puerperal Septicæmia and Peritonitis, by **Chas. P. Noble**, Philadelphia, 1895.——Diphtheria Antitoxine in Private Practice, by **Lloyd M. Bergen**, Highland Park, Ill. 1895.——The Hospitals of Europe, by **M. A. Goldstein**, St. Louis, 1894.——Removal of Septic or Infectious Matter with a View of Relieving Phlegmasia Alba Dolens, by **Geo. H. Noble**, Atlanta, Ga., 1894.

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OF THE

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CHARLES E. SAJOUS, M.D., EDITOR-IN-CHIEF,

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(End of Editorial Department of Journal for October, 1895.)

SOME OBSERVATIONS REGARDING THE THERAPY OF AMMONOL AND ITS COMBINATIONS.

By Cyrus Edson, M.D.

One of the first things a physician must do when called to treat a suffering patient is to relieve pain. Until within the past few years a therapeutic sacrifice had to be made in the majority of cases to attain this result. Our mainstay for analgesia was the opiate, and it was often contra-indicated by conditions underlying the cause of the painful symptoms. The discovery of the coal-tar synthetical products, and particularly Ammonol, has changed all this. Now we can relieve painful symptoms, and at the same time effect a powerful curative action on the underlying conditions. For instance, in rheumatic fevers the painful joints and muscles are the most distressing symptoms. Formerly we were frequently compelled to resort to morphia in order to give our patient relief quickly, but morphia retards waste and tends to prevent the elimination of products that are a more or less direct cause of the pain. Now, by combining salicylic acid with Ammonol, the pain is quickly removed after giving two powders of 10 to 20 grains of the Ammonol Salicylate, and the eliminative processes are stimulated; more than this, the Ammonol exerts a synergistic effect over the entire range of the effect of the salicylic acid. The compound resulting from the combination of the two is alkaline and far more effective than the sodium salicylate; moreover, it is tolerated easily by the most delicate stomach, and can be given when other salicylates cannot be borne.

Another instance may be pointed out in the use of Ammonol Peptonate in cases of gastralgia. Here we find in the combination a most efficient remedy for relief of pain following indigestion of food. The analgesic effect of the coal-tar derivative is almost immediate, while the re-enforcement of the gastric secretion by the pepsin enables the stomach to dispose of the food needed to run the system. The great value of Ammonol lies in the fact that it stimulates and renders the liver more effective to do its work. More than this, it is a synergist to very many drugs over their beneficial action, and antidotal over their harmful effects, just as was pointed out in the case of salicylic acid. The deranging effect of the acid on the stomach is completely neutralized.

LUPUS VULGARIS.

Dr. A. C. Richmond, of Washington, R. I., reports a case of lupus vulgaris affecting the alæ of the nose, a portion of the right cheek, the entire surface of the upper lip (internal and external), and the gums contiguous with the upper incisors. The internal treatment consisted of a mixture of iodide of potash, tincture of the chloride of iron, and Fowler's solution, while externally the following ointment was applied twice daily:—

℞ Acid. pyrogallic.,		gr. x.
Aristol,		gr. xx.
Lanolin,		
Cosmolin,	āā	℥ss.

Under this treatment an almost complete cure resulted in a short time. —*Atlantic Medical Weekly*, June 15, 1895.

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Selections from Society Proceedings.

FRANCE.

CONGRÈS FRANÇAIS DE MÉDECINE INTERNE.

Hyperglobulia and Vascular Neurasthenia.—M. JULES CHÉRON, of Paris, detailed the following experiment intended to produce instantaneous hyperglobulia and explaining the physiological mechanism of the condition. If the blood-cells of an anæmic or neurasthenic subject be first counted, the ratio of hæmoglobin and the arterial tension ascertained, and injection of artificial serum given (5 to 10 cubic centimetres—1¼ to 2½ fluidrachms—of a 1-per-cent. salt solution), there will be observed (1) a marked elevation of arterial tension; (2) an increase of the number of cells,—sometimes a fifth, a fourth, or even a third of the original number. Under the influence of stimulation by the hypodermatic injection of the entire circulatory system, through the central nervous system, the vascular system contracts, its capacity diminishes; the liquid part of the blood, much compressed, escapes into the perivascular tissues; while the red cells, being contained in a much smaller quantity of fluid, appear much more numerous in a given space. This is the mechanism of instantaneous hyperglobulia observed in man and animals in high altitudes. Dr. Chéron thought that this experiment might have a certain importance as bearing on the pathogeny and treatment of anæmia, many cases of which depend upon this ptosis of the circulatory apparatus, and which he designated as vascular neurasthenia.

M. DE FLEURY, of Paris, had had occasion to repeat this experiment three times, the results entirely confirming those of M. Chéron. He had also seen, in a neurasthenic patient, a constant hypoglobulia and arterial hypotension change suddenly to hyperglobulia with great hypertension under the influence of the atmospheric changes incident to a snow-storm.

He, therefore, believed that, generally speaking, the number of globules is far less stable than is supposed, and that it varies with strong moral or physical excitement. M. Chéron's experiment may thus explain some of the external signs of emotion. In joy, for instance, the bright color of the face has hitherto been ascribed to passive dilatation of the arterioles of the face, contrasting with increased tonicity of the rest of the organism; while from this experiment it could be attributed to concentration of the blood, a heaping up of the globules, thus making the blood much redder.

M. Chéron coincided with this view, having seen, after injections of serum, the faces of anæmic and neurasthenic patients become markedly redder, the increase of color immediately following the hyperglobulia.

Antipyrin in Diseases of Children.—M. Comby expressed the opinion that antipyrin can be given to children as an antipyretic, an antispasmodic, an analgesic, and to check diarrhœa. The drug is well borne by children of all ages and can be given in large doses. Only once in hundreds of cases has he seen a slight fugitive erythema caused by its administration. It has never in his experience caused disorder of the stomach or intestine, vomiting, or any ill effect on the kidney. In children suffering from febrile or spasmodic (chorea) diseases, antipyrin should not be given in fractional but in large doses to produce its full effect. According to the age of the patient 0.25, 0.50, or 1 gramme (4, 7¾, or 15½ grains) should be given at a time; this dose may be repeated two, three, five, and even six times a day. The same doses may be continued for weeks without ill effect. In chorea, antipyrin, as a rule, diminishes the violence and disorderliness of the movements and shortens the duration of the disease. In whooping-cough antipyrin has failed in the author's hands. In painful affections and in infantile hyperæsthesiæ it is unreliable, but Comby admits that his experience on this point is not sufficient to base a final conclusion upon. In fevers antipyrin causes a notable reduction of temperature; it is one of the surest of antipyretics, and may be used without fear. When antipyrin in a sufficient dose does not lower the temperature it is a prognostic sign of ill omen. In the simple diarrhœa of nurslings antipyrin is neither so powerful nor so sure in its effect as in febrile or spasmodic affections.

Diabetes.—M. Ausset stated that he had given to dogs from which the pancreas had been completely extirpated—as proved by post-mortem examination—calves' pancreas lightly cooked and mixed with the animals' food. The glycosuria caused by the operation always disappeared as soon as the treatment was begun, and this effect lasted as long as the administration of pancreas was continued. The treatment was tried in a diabetic man passing 38 grammes (1¼ ounces) of sugar in the twenty-four hours, with more than double the normal elimination of chlorides and phosphates, loss of strength, etc. On the second day of the treatment the amount fell to 4 grammes (1 drachm), and the quantity of salts eliminated became normal. On the ninth day the sugar had wholly disappeared and the urine remained normal for more than a month.

Cassaet reported good results in three cases of diabetes by the administration of brewers' yeast in a daily dose of 50 grammes (1½ ounces),

although the administration of the substance could not be continued sufficiently long on account of the practical difficulty in summer of preventing acetous or putrid fermentation. It was taken readily by the patients. The immediate effect was the expulsion, during the few minutes following its absorption, of a very large quantity of gas by eructation; then in the course of the first or second day extremely fetid diarrhœa with abundant gas occurred. After a few days tolerance was established, the patient felt better than he had done for a long time; his general state improved, his appetite returned, his strength increased, and pain diminished. The weight of the three patients in whom the treatment was tried increased three, five, and eight pounds, respectively, after the yeast had been administered for a fortnight. The gain in weight was particularly remarkable, inasmuch as one of them was phthisical as well as diabetic, and another had diabetes of the gravest type. On discontinuing the treatment loss of weight was soon observed again. As regards strength, as tested by the dynamometer, an improvement from 12 to 20 kilos (26½ to 44 pounds) was noted in the right hand, and of 17 to 22 kilos (37½ to 48½ pounds) in the left. As regards the urine the urea remained stationary or increased, and the proportion of sugar diminished in one case by three-fourths and in another by two-thirds in the fortnight.

Guaiacol Externally.—M. Lannois read, on behalf of Bard, of Lyons, a paper on this subject, in which it was stated that the external application of guaiacol may be dangerous, first by the sudden fall of temperature which immediately follows the application, and, secondly, by the nervous depression produced by repeated applications. Bard distinguishes the antithermic effect, which is transitory, from the antipyretic effect, which is lasting. In typhoid fever the method should not be employed on account of the long duration of the disease; in erysipelas and in pneumonia on the other hand, it is very useful. In tuberculosis its effect is favorable only in a certain number of cases of interstitial granular formations without complications, such as suppuration, peripheral pneumonia, etc.

Rondot, in the discussion, stated that, applied to the skin, guaiacol causes lowering of the temperature with profuse sweating, these two effects not always being of equal intensity. It sometimes happens that two or three hours after the temperature has begun to fall it rises again to a high level; this is a reactional pyrexia which must be taken into account. There are, indeed, cases in which the temperature, instead of going down, at once rises from one-half to one degree. Contrary to what is seen after the administration of other antipyretics, guaiacol causes polyuria. It is important to regulate the dose, as alarming hypothermia has been seen in some cases. A solution of 0.50 gramme (7¾ grains) of guaiacol in oil or glycerin should be employed. Applied to the skin the drug is useful in all febrile manifestations of tuberculosis. In fevers, both in children and in adults, it is sometimes very serviceable, especially in typhoid. The application should be accompanied by the administration of heart tonics.—*British Medical Journal*, August 31, 1895.

ACADÉMIE DE MÉDECINE, PARIS.

Diagnosis of Extra-uterine Pregnancy at Six Months; Operation Near Term.—M. PINARD reported the following, which he regards as an ideal case: The patient was aged 36, had had no illness, and had been regular from the age of 14 till July, 1894. During August of that year she had nausea and vomiting; on the 22d and 23d she lost a fluid which was slightly pink. The symptoms continued during September, on the 22d and 23d of which month there was a similar loss. In October she was kept in bed for two days by abdominal pain, which re-appeared in November, and was then associated with pain in micturition and defecation. From that time till February 26, 1895, when she came under Pinard's care, she was attended by several doctors, each of whom adopted a different diagnosis and treatment. One of them, thinking she had a fibroid, made her take in all about an ounce of savin-powder, which did not, however, produce any ill effect. When admitted she looked ill and pinched. The left thigh and leg were painful and œdematous. The abdomen looked like that of the sixth month of pregnancy. The abdominal wall was tense, smooth, and without lineæ albicantes. Palpation revealed a cystic, immobile tumor, extending two inches above the umbilicus and apparently fixed by deep adhesions. The fœtal parts could only be made out with difficulty by deep palpation, but the heart-sounds were easily heard to the right of and below the umbilicus. By the right side of this tumor a small one, the size of a tangerine orange, hardened and softened under examination. When contracted the groove between it and the large tumor became evident. Vaginal examination showed that the cervix, which was slightly deflected forward and to the right, and softened as in uterine gestation, was continuous with the small tumor. Cephalic ballottement was obtained in the large tumor. No sound was passed into the uterus for fear of setting up reflex action; the diagnosis of extra-uterine gestation at about six and one-half months with a living child was established without requiring to be clinched by proving the uterus empty. The patient was kept absolutely at rest in bed, and the œdema of the left leg cured by position. On April 30th the fundus of the tumor was 35 centimetres above the symphysis and the uterus 11½ centimetres; the cervix was as soft as that of a primipara at term. Operation, May 2d: Uterus found empty, cavity 14½ centimetres long. Median incision in abdominal wall; cyst-walls exposed; seen to be very slight and filled with enormous vessels, some greater than the little finger. On seizing the wall one of these vessels burst, and the hæmorrhage was only rendered greater on attempting to secure it, so great was the friability of the walls. The cyst was therefore rapidly opened and the child extracted by the foot. Hæmorrhage was restrained first by pressure of the hands, then by pressure forceps and ligatures. The walls of the cyst were sewn to the margins of the abdominal wound, the edge of the placenta being included in the suture. A wound was thus formed 10 centimetres in diameter, with the placenta for its base; it was filled with iodoform and salicylic gauze. The operation lasted an hour, and the child, a boy weighing 5½ pounds, after a brief period of respiratory difficulty, was seen to be perfectly vigorous. There was at first a

slight facial asymmetry, and a depression on the left upper jaw caused by the point of the left shoulder, against which it had been pressed in the cyst; these soon disappeared, and on the ninetieth day the boy weighed 12 pounds. The maternal wound was not dressed till May 13th, when it was washed with biniodide, 1 in 4000. The placenta came away piecemeal between May 25th and June 2d. The wound healed up, and the patient got up on the forty-third day, having suckled her infant from the first day after its birth. Pinard comments on the rare occurrence of ectopic gestation in a primipara with no history of affection of the abdominal or genital organs. The symptomatology was, except for the absence of an expelled decidua, characteristic, the presence of two tumors having the characters described being pathognomonic. The fœtal members, contrary to what is stated in books, are harder to feel in ectopic than in uterine gestation. With regard to treatment, Pinard modifies Werth's dictum as follows: "Every diagnosed extra-uterine pregnancy calls for surgical interference." In the first half of pregnancy, or when a fœtus has been dead two months, the cyst should, as Werth suggests, be treated as a malignant growth. When the fœtus has been dead but a short time, Pinard prefers the remote risk of suppuration to the certain one of hæmorrhage; if any untoward symptoms come on he at once removes the fœtus. If the fœtus is alive and 6 months old, he delays operation till it is viable, which in extra-uterine fœtation is not till the ninth month, the risk to the mother from hæmorrhage being in nowise increased by waiting after the placenta is once fully formed. The cardinal point in the operation is not to touch the placenta or to extirpate the sac. The possibility of septicæmia from retention is slight, while the hæmorrhage in immediate extraction is enormous and often uncontrollable. He sums up the point in these words: "The removal of the cyst is, perhaps, more surgical, but certainly less prudent." He has not had one bad accident in sixteen cases in which the placenta was treated as in this one. Daily irrigation with 1 in 4000 biniodide produces no toxic effect. With regard to the child, deformities are frequent in extra-uterine fœtuses, and are comparable to those in the children of primiparæ with little amniotic fluid and resistant uterine walls. The child is also likely, as in Cæsarian section, to suffer from a special kind of shock causing a temporary difficulty in respiration. The mother and child were shown to the Académie.—*British Medical Journal*, August 31, 1895.

GERMANY.

VERSAMMLUNG DEUTSCHER NATURFORSCHER UND AERZTE, LUBECK.

Diphtheria-Serum Treatment.—It was natural that this subject should be discussed once more at the great meeting of German scientists and physicians, and that its introducer should be DR. BEHRING himself. Without following either the introductory address or the subsequent papers and discussion too closely, it is sufficient to say that, on the whole, there was an air of satisfaction in dealing with the subject. Speaking of the report of

the Collective Investigation Committee, Dr. Behring claimed that the mortality reported was 9.6 per cent. higher than it would have been if the cases in which the prognosis was bad had not been specially selected for the serum treatment. The most convincing reports had been received from Giessen and Amsterdam. The former showed that the mortality in cases where tracheotomy had been performed had been reduced by serum treatment from 53 to 15 per cent., and, further, that the proportion of cases requiring tracheotomy had been considerably reduced, as by timely use of large doses of serum the spread of the disease to the larynx had been prevented.

The expression in regard to the use of the material as an immunizing agent had been of a somewhat Utopian character; he had reckoned that the requirements for this purpose in Europe and America would be from one to two million curative doses. Thanks to Ehrlich, the Höchster factory would be able to turn out over a million such doses. The most important and most recently noted point was the qualitative improvement. Whilst the curative dose had been hitherto contained in 5 cubic centimetres (1¼ drachms) of serum, the Höchster factory now manufactured one in which the dose was contained in only 1 cubic centimetre (15½ minims); ½ cubic centimetre (7¾ minims) was, therefore, sufficient for immunization. From this serum no unpleasant accompaniments need any longer be feared.

In conclusion, the speaker referred to the serum treatment of other infective diseases. As regards cholera, Ransom had stated that he had prepared a cholera antitoxin that rendered harmless two to three times the minimal fatal dose of cholera poison. The serum treatment of tetanus had entered upon a stage that promised good results. In speaking of the serum treatment of tuberculosis the speaker took occasion to do honor to Koch, the gifted and misunderstood discoverer of the new method of treatment. He remarked emphatically that, when tuberculosis was once successfully treated with antituberculin it should not be forgotten that it was Koch who first started the movement. He had no fear that antitoxin-serum treatment would ever disappear.

At a combined sitting of the sections for Internal Medicine, Hygiene, Surgery, and Children's Diseases, Professor Heubner, of Berlin, spoke on the same subject. His observation extended to 300 cases occurring in the space of two years. Amongst the pure diphtheria cases, 174 in number, the mortality was 8.6 per cent.; in the mixed infections, 46 in number, it was 21.7 per cent. In 110 cases that came under treatment during the first three days of the illness the mortality was 5.4 per cent. As regarded immunization by serum this, at present, did not last longer than three to four weeks. The speaker, although in favor of symptomatic treatment, was opposed to local treatment, as the excitement incident to it had a bad effect on the heart. He even avoided any unnecessary examination of the mouth, for the same reason. He recommended copious drinking of water to cleanse the mouth, sudorifics in the shape of packing, and liq. ammon. anisat., as well as expectorants, in threatening collapse.

Herr Soltmann said the results of antitoxin treatment could not be

denied. The statistics in Leipzig had been strikingly favorable, in spite of the serious character of the disease.

BEHRING, in reply, said that he had found carbolic acid the only reliable disinfectant in all cases. It was the only one he made use of, especially as, since a concentrated serum was used, not much was required in the shape of antiseptics.—*Medical Press and Circular*, October 16, 1895.

Arterial Pressure in Uræmia.—PROFESSOR VON ZIEMSSEN, of Munich, in a paper on this subject, stated that the intensity of the uræmic condition is accurately expressed by the arterial pressure, which undergoes great elevation. If, for example, it is from 160 to 170 millimetres at the first signs of the attack, it will rise steadily during the attack and slowly descend after it has terminated. This hypertension of the arterial system undoubtedly results from vaso-constrictor irritation by toxic substances not eliminated by the urine. Attempts to counteract this vaso-constriction by means of nitrite of amyl have so far been unsuccessful, either because the poison has an intense action or because there are other factors at work in the production of a uræmic attack. Arterial hypertension is not, however, constant, but it is of value in the prognosis and also in indicating suitable therapeutic measures.

GREAT BRITAIN AND COLONIES.

CANADIAN MEDICAL ASSOCIATION, KINGSTON.

Diagnosis and Treatment of Retrodisplacements of the Uterus.—DR. LAPTHORN SMITH, of Montreal, attributed the causation of this condition to miscarriages, forced labors, overstrain, falls on the back. Relaxed conditions of the muscular system in which the round ligaments shared was another predisposing cause. The diagnosis in uncomplicated cases was easy, but when there was associated displacement of the ovaries or tubes, with an inflammatory condition present, the diagnosis was not so easy. In such cases, if the sound were used, it should be introduced very gently. Methods of replacement were then described. In cases where operative procedure was necessary to retain the uterus in place he recommended Alexander's operation or ventro-fixation, the technique of which he gave.

DR. FARREL, of Halifax, when operating in these cases had an assistant hold the uterus up with a sound, and in this way a much smaller incision was required. In one case which he had operated on the patient showed signs of intestinal obstruction four days after operation. After placing the patient in the Trendelenburg position and shaking the hips strongly, a sudden and severe pain announced the fact that the obstruction had disappeared.

SIR WILLIAM HINGSTON believed that retroversion without adhesion was not difficult to deal with. With patience it would not be necessary to resort to Alexander's operation or ventro-fixation. With a stem-pessary the uterus might be kept in position for a few weeks, when the organ would retain its position unaided. He preferred ventro-fixation to Alexander's operation.

Dr. White, of St. John, reported a case in which he had done ventro-fixation. The uterus was healthy, but enlarged.

Cold Baths in the Treatment of Typhoid Fever.—Dr. Osler, of Baltimore, gave the result of five years' experience with this form of treatment. He stated that when the patient's temperature rose above 102½° F. (39.2° C.) he was placed in a bath at 70° F. (21.1° C.) every third hour. To patients with heart-weakness strychnine and alcohol in small doses were given, particularly after the bath. Milk, broths, and egg-albumen constituted the diet. Three hundred and fifty-six cases had come under treatment in the hospital, with twenty-five deaths. The mortality was 7.02 per cent. of all cases and 6.3 per cent. of the bath cases. It was to be remembered that hospitals were usually given the worst cases. In certain cases the baths were contra-indicated—as where the temperature did not rise to 102½° F. (39.2° C.) in very mild cases—in cases markedly asthenic, and where serious complications were present, as hæmorrhage, perforation, etc. The Brand method had thus not been strictly followed. The beneficial effect was not wholly due to the antipyretic action, but to the general tonic effect. Although not in favor of the treatment at one time, he had become an advocate of it, having seen its good effects in his own cases, as well as in those of the large hospitals in other portions of the globe. From statistics gathered it gave better results than any other form of treatment.

Dr. Muir, of Truro, N. S., referred to annual epidemics of typhoid he had experienced following river freshets. He pointed out the difficulties of carrying out the cold-bath treatment in private practice, of the opposition of the patient's friends, and of the danger to the medical man's reputation if serious results followed the cold baths. He condemned the use of the ordinary antipyretics. His watchword was: Watch the pulse, not the temperature. The speaker said most of his patients died from bowel complications in the third or fourth week. To avoid constipation he used small doses of Rochelle salts, and, for an antipyretic, alcohol. His death-rate was 8.1 per cent. in 159 cases.—*Montreal Medical Journal*, September, 1895.

Physical Training and Development as a Therapeutic Measure.—Dr. B. E. McKenzie, of Toronto, read a paper with this title. He drew a strong distinction between "athletics," an exercise for sport, and "gymnastics" combined with "massage," being an exercise not only for the development of muscular strength and proficiency in certain lines, but for the improvement in, and often obliteration of, serious deformities. He spoke mostly with regard to the physical training of women, especially those who suffered from muscular or osseous abnormalities. He claimed that the woman of modern times is not to be compared with her ancestor of ancient times in the matter of physical development, and that the difference practically arose from the evils of modern dress. By careful physical training, even those afflicted with spinal curvature may be helped materially, and perhaps entirely cured. He strongly advocated a system of training (by classes, if possible). The patient was to be placed before a mirror, and those muscles upon which the deformities depend are to be brought into forced action according to a graduated system prescribed by the trainer, and the proper position taken.

He further said that such treatment invariably tended to aid the functions of all the vital organs, to improve appetite, mental capacity, and all the physiological functions of the body, at the same time increasing the chest-measure, height, and weight.

Dr. McKenzie then gave the history of one or two cases treated by gymnastics, one being of a girl of 22, with spinal curvature accompanied with pain, in which the treatment was entirely successful; and another of a boy of 7 years, with rota-lateral curvature, accompanied by chorea. Complete control of the muscles was gained in less than a week, and entire recovery ensued. He quoted Dr. Crighton Browne as a strong advocate of physical training in muscular abnormalities, who claims that the system is also of benefit to criminals and imbeciles. The speaker concluded with the assertion that the medical profession did not pay enough attention to this subject, that modern methods of living render it imperative, and that the treatment must be used in connection with current approved methods. He also recommended that physical training should be carried on in all schools.

Dr. Louis A. Sayre, of New York, said that the subject of physical training was one of the greatest importance that could be brought before the profession. He was glad to see that it was receiving more recognition than formerly. Physical training was one of the principal elements in the sustenance of a nation. It had a marked effect on the mental and moral force of a people. A good mental condition was dependent on proper nutrition and exercise. The training, he said, must be systematic. He then spoke of the causes of lateral curvature and commended the treatment that Dr. McKenzie had advocated—of mental and physical training, using no instruments, no machinery of any kind, plaster-of-Paris supports, or splints of any sort. A judicious teacher was necessary to train the children in these exercises. He related the history of a case that had come under his attention in which the patient, a small boy, weak and frail in body, was mentally an imbecile. Under the treatment the progress, both physical and mental, was exceedingly gratifying. By continuance of the treatment he was sure that the boy would make a useful man.

Dr. Reginald H. Sayre, of New York, said that under this treatment he had found that the life of a child was changed from that of a mere animal to that of a rational human being. To those who had not witnessed the results of the treatment it would be a revelation. He spoke more particularly of the effects of training in certain forms of rickets. To properly treat these cases it was absolutely necessary that the physician exercise a very great deal of patience and perseverance. This system of treatment had suffered because of the great numbers of people who had gone into the business who understood little or nothing about it. The effects of proper treatment were particularly noticeable on the muscular, nervous, and circulatory systems. In certain advanced cases, where the bones were deformed so that walking was difficult, he advised the use of supports until the muscles, unaided, were strong enough to support the patient. He then referred to the necessity of improvement in school in regard to exercises and gymnastics. He also pointed out the danger of overtraining, as was seen in those training for athletic contests.

DR. RODDICK, of Montreal, gave his experience with these cases. In certain cases he had found that, in addition to the training, supports were needed, especially in the intervals between the exercises. He had secured a competent instructress. It was absolutely necessary that this training should be relegated to some one who would perform the duties intelligently. He could speak in the highest terms of this line of treatment in these spinal cases. He said that in the less pronounced cases a cure could certainly be promised. The speaker then entered into a classification of these cases and dealt with the appropriate form of treatment for each. He said the mistake was often made of developing the muscles on the strong side overmuch and thus aggravating the mischief. He referred to recent observations he had made in Egypt in regard to spinal deformity. He was surprised to learn that they had no cases of this sort there. He believed this was due to the fact that they were in the habit of having the girls carry water-bottles on the head; in this way the muscles of the head and trunk were strengthened. He had introduced this principle in his classes—of having those under training carry weights on their heads as a part of the exercises they perform for the correction of their deformity.—*Medical Record*, September 14, 1895.

EDINBURGH MEDICO-CHIRURGICAL SOCIETY.

Skin-Grafting from the Lower Animals.—While fully appreciating the value of Thiersch's method of skin-grafting, DR. ALEXANDER MILES points out that it has the drawbacks common to all operations involving the use of a knife on the person of the patient and the administration of an anæsthetic. These can be overcome by employing the skin of young animals killed for the purpose. He has used dogs, rabbits, kittens, and frogs as the donors of skin, the best results having been obtained from dogs and the least satisfactory from frogs. Young animals are always used. The ulcer is prepared, as in other skin-grafting procedures, by being made aseptic and by being brought into a healthy state as regards its granulations, which must be neither redundant nor œdematous. The grafts are placed on the surface of the granulations without previous scraping. The preparation of the grafts consists in killing the animal, and, after shaving its abdomen, dissecting up the whole skin, leaving behind the subcutaneous tissue. It is floated out in warm boracic lotion, and cut into pieces varying in size according to the raw surface to be covered in (from 1 inch by ½ inch to 6 inches by 1 inch). These are firmly pressed into the granulating surface, close up to the margins and edge to edge. A dressing of protective, gauze and wool, with a splint, is then applied. The after-dressing is the most important part of the proceeding. It should be left undisturbed for at least forty-eight or seventy-two hours, and then the dressing should be changed with the utmost gentleness and caution. Subsequent dressings may be necessary every day, or every second day, according to circumstances. A graft which dies should be removed at once, to avoid septic changes taking place. Apparent sloughing of a graft is occasionally observed. It is due to the superficial layers of the skin being thrown off, the more vital, deep

layers living and growing. When pustules form on a recently-grafted surface they should be punctured at once and covered with an antiseptic dressing. Granulations sometimes grow up through grafts, destroying them. These are best removed with a sharp spoon. In all cases special precautions are necessary to prevent movement of parts until the grafts have fairly established themselves.

Details of ten cases treated by grafting from animals were given by Dr. Miles. The results of the grafting in four were perfectly satisfactory. Two patients recommended for amputation, and anxious to have it done, left the hospital with useful limbs. In another an ulcer, which had resisted ordinary treatment for eight months, was healed in a week. In the fourth case an ulcer, sixteen inches by twelve inches, was reduced to the size of a shilling-piece, when it was attacked by erysipelas, to which the patient succumbed. Four other cases were only partially successful,—some of the grafts taking, others failing. Two cases derived no benefit whatever from the proceeding. The resulting scars are stronger and show less tendency to contract than those obtained by any other method of grafting. Pigment speedily disappears, and no hair, sweat, or sebaceous matter appears on the new skin.—*Edinburgh Medical Journal*, September, 1895.

ITALY.

Fifth International Congress of Otology.

Adenoid Vegetations.—M. Arslan, of Padua, commented on the frequency of adenoid vegetations in Italy, stating that, of 315 children examined in the schools of Padua, he had found the growths present in two-thirds of them. He was inclined to attribute the preponderating rôle to heredity, a number of his patients showing that their antecedents presented exactly the same symptoms. In six cases he had brought about the cure of stridulous laryngitis by the removal of adenoid vegetations, and in another case the symptoms of Jacksonian epilepsy disappeared in the same manner. He uses Gottstein's curette in operating, with bromide of ethyl as an anæsthetic. He never employs cocaine in children. It is customary to establish the diagnosis by means of rhino-pharyngeal palpation, but he finds that in most cases posterior rhinoscopy is sufficient.

Dr. Gradenigo, of Turin, prefers chloroform to bromide of ethyl, and Dr. Goris, of Brussels, has also used chloroform successfully. If the child be lying down and the head lowered, there is no danger of the tumors dropping into the larynx.

Dr. Cresswell Baber, of Brighton, has for some years used a mixture of protoxide of nitrogen and ether, and heartily recommends it. He believes that the prognosis should always be guarded, since if the growths be of the tuberculous type, described by M. Lermoyez, the issue of the case cannot be foretold.

Dr. Helme, of Paris, regards it as dangerous as well as useless to employ cocaine in children. The drug removes the pain, but it does not remove

the apprehension of the little patient, and we give an anæsthetic for the purpose of being able to operate without any movements on the part of the patient. This requirement is met with by bromide of ethyl, which has the advantage of immediately acting on the brain; and though its effect is transitory, there is sufficient time to properly perform the operation. The introduction of the finger into the cavity after operation he looks upon as a dangerous procedure, in view of the difficulty of having the index finger rigorously aseptic in an operation which must be so rapidly performed.

M. Sécrétan, of Lausanne, never administers an anæsthetic in these cases.

M. Moure, of Bordeaux, believes that in certain cases anæsthesia is necessary, in others it is not. The indications must be based not only on the docility of the patient, but also on the size and situation of the growths. In certain cases, in which the vegetations are near the tubes, anæsthesia is required, curettage being a somewhat delicate matter. For simple vegetations of the choanæ anæsthesia is not indispensable.

Dr. Dundas Grant, of London, is a warm partisan of bromide of ethyl, and never operates in these cases without it.—*Médecine Moderne*, October 9, 1895.

Turbinal Hypertrophy in Relation to Deafness.—Dr. H. Macnaughton Jones, of London, in a paper on this subject, with especial reference to the operation of turbinotomy, advanced the following conclusions: 1. Turbinal hypertrophy must be regarded as a serious complication of deafness and the allied aural disorders; in those cases in which it precedes the aural symptoms it may justly be looked upon as a principal cause of these. 2. In all cases in which the hypertrophic change is discovered, active therapeutic measures, of which the chief is the galvano-cautery, should be adopted to reduce it. 3. Deviation or distortion of or growths from the septum are rarely, if ever, causes of deafness, and only become such when they complicate turbinal hypertrophy. 4. In all cases in which the occlusion of a nostril is found to be in part due to septal deviation or growth, this deviation should be rectified 5. Turbinotomy is indicated in, and should be reserved for, those cases in which, either from the size or nature of the growth, it is useless to hope for improvement from other treatment. This can occur in but relatively a very small proportion of aural cases.—*Medical Press and Circular*, October 16, 1895.

NORWAY AND SWEDEN.

Second Congress of Swedish and Norwegian Surgeons, Christiania.

Intestinal Paralysis After Laparotomy.—Dr. Engstroem reported a case of interest as bearing on the cause of death in paralysis of this nature, a cause supposed by some to be intestinal intoxication, by others subacute septicæmia. The patient, a woman of 37 years, had undergone an operation for sarcoma of the right ovary. In the course of the ovariotomy the sanguinolent fluid in the peritoneum was sponged out, the intestinal loops

being thus subjected to mechanical irritation. The same evening vomiting supervened, continuing the next day, while the pulse became small and the abdomen dilated. Symptoms of intestinal obstruction appeared in the days following and the patient died on the fifth day after operation, half an hour after a second laparotomy, which had shown the absence of any obstacle to the fæcal circulation. Bacteriological examination of the peritoneum and its contents an hour after death gave absolutely negative results, and a complete autopsy five hours later showed that there was no peritonitis or septic infection.

Murphy's Button in Intestinal Anastomosis.—Dr. Borelius stated that he had had occasion to use Murphy's button in five cases. In one case of gastro-enterostomy the button had not passed out after a period of six months from operation, and he was of the opinion that it had fallen into the stomach. In three cases of gangrenous hernia recovery was uneventful and the button was passed from the eighth to the fifteenth day after operation. One patient, operated on for ileus, succumbed to peritonitis,—probably caused by the button.

Dr. Tscherning used the button in one case of gastro-enterostomy for cancer of the pylorus and in another of resection of the colon. At the autopsy of the first patient, who died of inanition some time after operation, the button was found in the stomach; the second patient died of post-operative peritonitis, which, however, the speaker did not attribute to the button.

Dr. Malthe used the button in one case of gastro-enterostomy and three cases of pylorectomy. In one of the latter cases he did not employ sutures above the button and a fistula formed, through which the stomach-contents passed into the abdominal cavity, the patient dying.

RUSSIA.

Medical Society of Kieff.

Pain, Fear, and Shock.—Prof. J. Likorsky, in a study of these states, finds, like many other observers, that, though apparently widely different, they have much in common. (*Médecine Moderne*, August 31, 1895.) Shock and pain are always accompanied by the following series of constant phenomena: 1. Alteration of the pupils. Mydriasis is a reflex symptom due to excitation of the sensitive nerves, and is always present in any painful irritation. 2. Weakness of the voluntary muscular system—inhibition of the motor centres due to painful irritation of the sensitive nerves, and analogous to the arrest of the respiratory muscles on the affected side in pleuro pneumonia. 3. Modification in respiration, also due to the same cause. 4. Cardio-muscular symptoms, the vasomotors being especially sensitive. Painful irritation of the sensitive nerves causes a vascular spasm, soon followed by vasomotor paralysis. This in turn leads to a fall of blood-pressure and diminishes the number and strength of heart-beats. 5. Alterations in nutrition and body-temperature. These depend on trophic troubles

due to shock or pain. Arrest of nutrition exchanges leads to respiratory disturbance, the blood being too poor to properly stimulate the respiratory centres. 6. Alteration in the psychical functions. These, like the physiological functions, are more or less depressed in shock; even pain, the primary manifestation, is much diminished,—a fact which led Dupuytren to remark that a too great loss of sensibility could cause death as readily as a too great loss of blood.

Fear, by its objective signs, is closely allied to pain and shock. It is the prototype of all the psychical emotions and the same symptoms may be observed in them. Excessive fear may lead to death in the same manner as pain and shock. In criminals on the way to execution, excessive cardiac weakness has been noted, with extreme pallor, cyanosis, muscular weakness preventing them from walking, and arrest of all the secretions except perspiration. In some there is a sort of precipitation and restlessness like that seen in erethic shock, and sudden death has been observed immediately before execution, while surgeons have met with many cases of sudden death in nervous patients before an operation.

As regards the pathogeny of these conditions, authors are in accord in admitting a rôle of two essential factors—the excitation of certain nervous systems, as a psychical organ or the peripheral nerves, and the arrest of functions in essential organs, as respiration, circulation, or nutrition. The mechanism of shock is complicated by the part taken by a psychical organ, and this is especially evident in hunger and pain. These two sensations are more dangerous and may easily lead to death when the patient is conscious of them. Fasting presents no danger to life when it is accompanied by anorexia. As Bernheim observes, a man whose appetite remains good may die without having lost half the weight that patients lose during a disease accompanied by anorexia and wasting. Typhic and tuberculous patients who fast from loss of appetite die more slowly than healthy men who fast.

Another factor of importance in these conditions is the concentration of the attention upon the impression expected. To this may often be attributed the sudden death occurring in the course of insignificant operations, such as catheterization of the œsophagus, bladder, etc., in nervous patients.

Society of Russian Physicians, St. Petersburg.

Leucolysis.—Dr. E. Botkin, of St. Petersburg, made a report on leucolysis, stating that two anomalies of the leucocytes of the blood were recognized,—viz., an increase in number, or leucocytosis, and a diminution in number, called leucopexy or leucolysis by Löwit, aleucocytosis by Gulzmann, and hypoleucocytosis by Goldscheider. This variety of names proves that the cause of the phenomenon is, as yet, little understood. Löwit attributes it in some cases, such as after injection of albuminoids and bacterial proteids, to destruction, dislodgment, and dissolution of the white cells. Such dissolution, in the sense intended by Löwit, cannot be proven; but the destruction of the white cells in the blood has been shown

beyond a doubt by Virchow, A. Schmidt, Rauschenbach, Ouskoff, Gabritschewsky, S. S. Botkin, Engel, Goldscheider, and many others.

In order to determine in what manner the leucocytes perished Botkin examined the blood of two healthy subjects, two patients with acute pneumonia, five with typhoid fever, and a convalescent from pneumonia with crepitant râles and general weakness. He was able to follow the progressive destruction of the leucocytes in cover-glass preparations subjected to different temperatures. The lymphocytes were destroyed more slowly, becoming more and more transparent, and being transformed, within ten minutes, into brilliant spheres in no way resembling their initial form. The first change in the leucocytes consisted in rupture of the corpuscles, with partial escape of the protoplasm, the form of the corpuscles and the quality of the protoplasm then gradually undergoing alteration. The granulations became fewer and larger and the protoplasm pale; the outlines of the cell became confused with the base of the preparation and gradually disappeared until only slight, and sometimes no, traces of the corpuscles remained. Within four minutes the leucocytes were not recognizable, and within eight minutes they had completely disappeared.

The percentage of destruction was less in proportion as the quantity contained in the blood was poor. The destruction was especially marked in pneumonia (94 per cent.), in which leucocytosis is pronounced (87.5 : 1). In typhoid fever, in which it is diminished (762 : 1), the destruction was only 23.1 per cent. It was greater in preparations kept at a fever heat than in the control preparations kept at the temperature of the room; but even in these latter the destruction of leucocytes was much more marked in the blood of pneumonia (64.3 per cent.) than in normal blood (from 23 to 28 per cent.).

By following this gradual destruction of the leucocytes outside of the organism a destruction not due to drying or to coagulation, as proven by the absence of fibrinous filaments as well as control experiment in a moist atmosphere, it is seen that such destruction is not due to the cessation of cellular life under the influence of cold or carbonic acid, but to physiochemical changes taking place in the white corpuscles and the blood-plasma.

UNITED STATES.

American Orthopædic Association, Chicago.

Tendon Transplantation in the Treatment of Deformities Resulting from Infantile Paralysis.—Dr. Joel E. Goldthwaite, of Boston, called attention to the possibility of furnishing better mechanical attachments for certain non-paralyzed or only partially-paralyzed muscles as a part of the treatment of infantile paralysis. He reported a number of cases in which the results had been most gratifying, and from which it appeared not unreasonable to class tendon transplantation with tenotomy and the other surgical procedures that had a place in the treatment of this condition. At the knee undoubtedly tendon transplantation could be employed to advantage in

a certain limited number of cases, and possibly at some of the other articulations, although the best results were to be looked for in those portions of the body where the tendons were well formed and lay superficially. The operation was not to be attempted upon the tendons of muscles which were wholly paralyzed, except possibly in rare instances for the purpose of furnishing an additional support of a purely tendinous character. It was conceivable that in the foot, for instance, if the tendons on the inner side were more atrophied and offered less resistance than those on the outer side, these tendons might be attached to the inner side and thus increase the lateral support. This was merely a suggestion, however, for it had not been tried practically, and the benefit to be derived from it would undoubtedly be slight. There was also a question as to whether or not two atrophied tendons would unite firmly, although from watching the other cases the author doubted if there would be any trouble on this account. The best results from tendon transplantation were to be obtained in cases in which one group of muscles had been destroyed, leaving the antagonizing or accessory muscles very little if at all impaired. This resulted in a definite deformity, which became more marked as the age increased. The best illustration of this was to be found in the condition, so commonly seen in the foot, where the gastrocnemius and the muscles at the inner side of the foot had been destroyed, the peroneal muscles retaining their normal contractility. The result was a valgus which constantly increased, both from the muscular contraction and from the faulty mechanical position in which the weight of the body must be received upon the foot in walking or in standing. This was also seen in connection with the anterior muscles of the foot; the anterior tibial and the extensor pollicis, so often being destroyed, left the peroneus tertius and the extensor communis digitorum the only muscles to be used in flexing the foot at the ankle. This also resulted in a valgus which steadily increased. To correct these mechanical conditions and to use the non-paralyzed muscles to the best advantage, the author had operated in four cases, and the tendons of the muscles had been given new attachments.

Deformities and Malformations Resulting from Acute Infections in Bone.—Dr. Roswell Park, of Buffalo, stated that, clinically, there were three situations in which bone infections were most commonly met with: beneath the periosteum, in the epiphyses, and in the diaphyses. From the pathological side, infections were of four main varieties: 1. The tubercular. 2. The staphylococcous. 3. The streptococcous. 4. The pneumococcous. To these might be added rare instances in which other organisms were primarily or secondarily present. Of these, certainly the more common was the tubercular form, whose manifestations were usually not acute. The three others might be grouped in a general way as pyogenic forms of invasion in which pus was practically invariably produced, provided only that sufficient time had elapsed. The author alluded to the acute miliary tuberculosis of bone, which corresponded in most essentials with similar invasions of the lungs, and of which he had seen occasional examples. It was not quite so rapid as the pyogenic forms, and it might take two or three weeks to produce

such destruction of the bone as to require operation. It stood, therefore, in an intermediate position between the acute infections and the slower (usually the tubercular) lesions. Nevertheless, it was sufficiently acute to demand prompt recognition, and when recognized might often be relieved by prompt operative interference. The course of a bone disease would depend first upon the location of the lesion, and secondly upon its character.

As showing the relative frequency of parts involved, in 30 cases observed by Kocher the disease had occurred thirteen times in the tibia and eleven times in the femur. In 98 cases collected by Leucke and Volkmann, the femur had been involved in 36, the tibia in 34, and the humerus in 11. Disease in the immediate neighborhood of the hip-joint was about five times as common as in that of the knee. Comparing epiphyses with diaphyses, and accepting Schede's 67 cases, of 28 cases in which the femur had been involved, half of them had been in the shaft and half in the diaphysis. In the tibia, of 27 cases, only 9 had concerned the epiphyses; and of 7 cases of the humerus, 2 had involved the epiphyses.

With regard to necrosis, it concerned orthopædists mainly in this: that it produced in many instances a weakening of the bone which might lead either to fracture, to deformity, or to curvature. Spontaneous fractures of necrotic bone had occurred under the writer's observation, and he remembered one case of a necrotic femur which had broken as he was lifting the patient upon the operating-table. Incidentally, there was danger of cancer in some of these cases, for Volkmann had collected thirty-two cases in which old and fistulous passages had become the site of epitheliomatous changes and in which cancer had been the final result.—*New York Medical Journal*, September 28, 1895.

AMERICAN ASSOCIATION OF OBSTETRICIANS AND GYNÆCOLOGISTS, CHICAGO.

Puerperal Sepsis.—DR. A. B. MILLER, of Syracuse, in a paper on this subject, summarized his views as follows: 1. Suspected infection of the birth-canal should be confirmed, when possible, by a bacteriological examination of vaginal secretions, and every means of distinguishing it from other affections should be resorted to, that it might be treated rationally either by medicine or surgery. 2. Irrigation and antiseptics destroyed the nutrition of the parts when continued, and, furnishing increased moisture, improved the field for the development of micro-organisms, aside from the danger of death resulting from the antiseptic used. 3. The birth-canal could be kept comparatively dry by absorbent dressing, removing the culture-media, and arresting the development of germs and infection until the abraded parts had been repaired.

DR. L. S. MCMURTRY, of Louisville, discussed the indications for operation in puerperal sepsis. Since operative surgery, a few years ago, had disclosed the various lesions of pelvic disease, it had been known that pregnancy and the puerperal state might be complicated by pre-existing inflammatory diseases of the uterine appendages, tumors, and septic accumulations inside the pelvis. Chronic and circumscribed disease of this character might be converted into acute and diffuse inflammatory conditions by the

trauma of labor. Puerperal sepsis might, in this way, be the result of pre-existing disease. This class of cases must necessarily be small, since women thus diseased were, as a rule, sterile. That such cases necessarily came within the scope of operative treatment would be generally conceded. The indication and guides for operative interference in this class of cases were also considered by the author. In all cases of puerperal sepsis the most careful examination of the pelvic organs should be made. He also alluded to the class of puerperal cases in which the local symptoms were those of diffuse peritonitis without localization of lesions, but where the uterus was presumably the focus of infection. This class of cases had recently been discussed extensively in relation to treatment by hysterectomy. Empirical operations in surgery were likely to prove more disastrous than similar methods of treatment in medicine. The gravity of such cases might often justify exploration and drainage, but the more extensive operation of hysterectomy would almost invariably prove disastrous.

Dr. W. E. B. Davis, of Birmingham, Ala., said, with reference to cases of puerperal sepsis, that, where the temperature ran high, the patients usually died in from a week to ten days, and he believed that surgery offered very little hope.

Dr. Herman E. Hayd, of Buffalo, said that, where a septic condition took place in the endometrium, or where there remained a portion of the placenta which broke down, he was satisfied that a sharp curette should be used. With a sharp curette the surgeon could scrape away a good piece of tissue and yet do very little harm.

Dr. William Warren Potter, of Buffalo, expressed the belief that there was no puerperal fever except that due to infection; that, if the history of these cases had been carefully traced, the gynæcologist would find underlying infection somewhere, which might be carried into the genital tract either by the obstetrician himself or by the environment of the puerperal woman; hence the great collateral interest of this subject was the one of preventive medicine. The important question was aseptic midwifery. If aseptic midwifery were practiced in every case, there would be no puerperal sepsis and no ophthalmia neonatorum.

Dr. W. P. Manton, of Detroit, stated that he had never had in his private practice a case of puerperal sepsis. In reference to the use of the curette it was an instrument, if properly used, which was absolutely devoid of harm.

Dr. H. W. Longyear believed that, when the uterus was packed full of gauze, it prevented the flow of mucus, blood, and serum. While more or less serum might possibly come away, fragments of placenta or blood-clots would certainly be retained. Rise of temperature, etc., should not be an indication for surgical interference in puerperal sepsis.

Dr. William H. Myers, of Fort Wayne, emphasized the importance of distinguishing between septicæmia and pyæmia in considering the subject under discussion.

Dr. C. C. Frederick said that, out of forty cases of puerperal septicæmia which he had seen in consultation in the last eight years, only two

patients had died. Nothing could be found in the uterus and there had hardly been any localized symptoms.

Dr. James F. W. Ross, of Toronto, said that the subject was of the greatest importance, inasmuch as a new craze at the present time had seized the profession, that of taking out the uterus in cases in which it was unnecessary, in his opinion, to remove that organ. The pendulum had swung too far, as it did when the removal of the ovaries was undertaken for vague symptoms, and the association should take some means of swinging it back again to its normal position.

Dr. W. G. Macdonald, of Albany, related a case in which he had favored the use of the sharp curette.

Dr. Sherwood Dunn, late of Paris, France, said that in the Broca Hospital, Paris, there were one hundred and eighty-four beds, forty-eight of which were devoted to obstetrical cases. In his three years' connection with the hospital service there, no case of confinement had ever been followed by any septic condition.

Dr. A. J. Burgess, of Milwaukee, said that, in cases of uterine traumatism, especially in abortions, where there was retained septic material within the uterus, it was absolutely impossible to curette it away with a dull instrument. He had seen the dull curette used for half an hour at a time, and yet, two days afterward, pieces of membrane or clots the size of a hen's egg had come away. With a sharp curette everything could be removed.

Dr. A. H. Cordier, of Kansas City, emphasized the importance of treating every case of puerperal sepsis as an individual one. Where surgical interference was called for, it must be resorted to early if we expected to save lives.

Dr. G. E. Krieger, of Chicago, predicted that in time we should treat puerperal sepsis very much in the same manner as we treated diphtheria, —with serum.

The president, Dr. J. H. Carstens, of Detroit, emphasized the importance of distinguishing between the different forms of infection. While the obstetrician might in some instances infect his patient, he believed in a self-infection. He thought a sharp curette was not necessary for removing the shreds of membrane or other *débris* that might be left.

Dr. Frederick Blume, of Pittsburgh, said it had been proved years ago that in 50 per cent. of healthy women there had been found streptococci or other pathogenic micro-organisms in the vagina. He used a sharp curette for curetting the uterus.

Parotiditis After Gynæcological Operations.—Dr. James F. W. Ross, of Toronto, narrated a case in which, after vaginal hysterectomy, on the tenth day after the operation, the temperature had risen to 103° F. (39.5° C.), and a swelling in each parotid gland had presented itself. The swelling had gradually increased. The sides of the face had become enormously swollen, the eyelids had become puffed, and the patient could scarcely open them. The complication he believed to be an unusual one. Double parotiditis was seen occasionally as one of the sequelæ of the infectious diseases,

—a distinctly septic disease. It was difficult to believe that the removal of the ovaries could produce it, and, if parotiditis had a peculiar tendency to follow the removal of the uterus, we should have sufficient data upon the subject to make us well aware of this fact also.

Dr. Edwin M. Ricketts, of Cincinnati, related a similar case in which, two days after the removal of the diseased appendages, a double parotiditis had made its appearance.

Dr. C. C. Frederick, of Buffalo, had seen a case, in the practice of a prominent practitioner in Buffalo a few years before, in which a double parotiditis had followed ovariotomy. The woman had made a good recovery. There had been no suppuration in the case.

Dr. James F. Baldwin, of Columbus, narrated an instance in which the parotiditis had been limited to the left side, and had followed a vaginal hysterectomy on about the third day. It had been accompanied by elevation of temperature, pain, and swelling.

Dr. W. G. Macdonald, of Albany, said that parotiditis associated with the removal of the uterine appendages was not a new thing. Among the earlier operations it had not been an unusual complication. The patients, however, usually died. He had seen one case following a supravaginal hysterectomy. He had also seen it after amputations of the thigh.

Dr. John M. Auld, of Chicago, had seen one case of non-suppurative parotiditis of one side. It had followed perineorrhaphy and an operation for hæmorrhoids.

Dr. H. W. Longyear, of Detroit, had seen parotiditis associated with typhoid fever.

Dr. A. H. Cordier, of Kansas City, said parotiditis occurred with greater frequency than was supposed in connection with operations involving the ovaries and tubes. He was inclined to believe that there was a sympathetic relationship between the ovaries and the parotid gland.

Dr. A. H. Ferguson, of Chicago, asked as to the condition of the patient's mouth at the time of the parotiditis. In scarlet fever, diphtheria, and a number of diseases associated with disease of the uterine appendages, extension took place to the parotid gland. In such cases the mouth was foul, and if it could be kept clean parotiditis was not so apt to occur.

Dr. Ross said it was well known that the parotid glands, the thyroid gland, and the submaxillary glands frequently became inflamed in inflammatory disease of the testicles, but as to inflammation of the ovaries we were not so sure. He could not say as to the condition of his patient's mouth at the time of the operation.—*New York Medical Journal*, October 5, 1895.

Syphilitic Alopecia.—Friction every other day with *bichloride of mercury*, 0.50 gramme (7¾ grains); *eau-de-Cologne*, 250 grammes (8 fluidounces). Twice a week with *yellow oxide of mercury*, 1 gramme (15½ grains); pure *vaselin*, 25 grammes (6½ drachms). (Brocq, *Jour. de Méd. et de Chir. prat.*, September 10, 1895.)

Selections from Reports of Members of the Annual's Staff of Correspondents.

Denmark.

DR. F. LEVISON,
REFERENT FOR DEN DANSK LITTERATUR VEDRÖRENDE: ALMINDELIG MEDICINSK PATHOLOGI OG THERAPI, DERI INDBEFATTET, NERVE- OG SINDSSYGDOMME, PÄDIATRIK, OBSTETRIK, GYNÄKOLOGI, HYGIEINE, DEMOGRAPHI, RETSMEDICIN, PATHOLOGISK, ANATOMI, BAKTERIOLOGI.

Alle medicinske Böger, Disputatser, Monographier, Tidsskrifter etc., der adkomme i Danmark bedes sendt til

DR. LEVISON,
Norrevoldgade, 13,
Köbenhavn.

Treatment of Mastitis.—KAARSBERG (*Hospitals-Tidende*, p. 573, 1895) was induced to try a new treatment of mastitis by having observed that a woman who would not allow incision of her inflamed breast was cured by evacuation of pus from the nipple through sucking and pressure on the inflamed portion of the breast. He has since treated seventeen cases of mastitis by evacuation of the breast partly by sucking and partly by a sort of massage by which the breast is compressed and gently rubbed in the direction of the nipple. This treatment is repeated two or three times every day. Thirteen cases of mastitis which came under observation from the first day of the disease recovered in a few days, and suckling of the child could be continued; four cases in which the inflammation had already led to formation of an abscess had to be treated by incision. The author remarks that veterinary surgeons always treat inflammation of the udder of the cow by milking it.

Myxœdema.—VERMEHREN ("Essay on Myxœdema." Copenhagen, 1895) relates sixteen cases of myxœdema treated with preparations of thyroid gland. In two of the cases exact calculation of the metabolic processes were made. The metabolism of proteids was found to be excessively small, not larger than in healthy persons in complete inanition and the proteids of the food were digested in a defective manner; when thyroid preparations were ingested more nitrogen was excreted and the whole metabolism was improved. When young and healthy persons took thyroid tablets no important effect was observed, but in elderly and somewhat senile persons the excretion of nitrogen increased, although neither the ingestion of proteids nor their digestion in the intestine was influenced by the use of thyroid extract; at the same time the weight of the body diminished and the pulse became more frequent. Acceleration of the respiration, rise of temperature, and increased diuresis were also observed, though not so constant.

Rheumatic Fever in Copenhagen.—LORENTZEN ("Rheumatic Fever in Copenhagen from 1887 to 1891." Copenhagen, 1895) has collected the cases of rheumatic fever recorded in the weekly lists for the years 1887 to 1891 in order to determine whether the frequency of the disease was dependent on meteorological changes, the nature of the soil, etc. His results show that it reached a maximum in the months from January to April and a minimum from July to September, but that it is not directly influenced either by the temperature of the air or by the height of the subsoil-water, the nature of the soil, or the density of population. Certain houses or

blocks are especially attacked by rheumatic fever, as proved by the frequent occurrence of house-epidemics.

Subnormal Temperatures.—SCHNICKER (*Hospitals-Tidende*, p. 721, 1895) and ZAHRTMANN (*Hospitals-Tidende*, p. 769, 1895) both report cases of very low temperature. In the two observations of the first author the temperature in the rectum was 34° C. (93.2° F.) and 26° C. (78.8° F.) several days before death; while in the case seen by Zahrtmann a temperature of 32.7° C. (89.6° F.) was noted after an attack of profuse bleeding from the kidneys, the patient recovering. These subnormal temperatures were all observed in asylums for the poor and destitute.

Bothriocephalus and Anæmia.—FABER (*Hospitals-Tidende*, p. 602, 1895) relates the case of a woman suffering from pernicious anæmia (blood-corpuscles 600,000 per cubic millimetre; hæmoglobin, measured by the apparatus of Gower, 20 per cent.). At the autopsy two strictures of the intestine were found, one 2¼ metres below the pylorus, the other 1½ metres lower down; in both places the bottom of the ulceration being formed by a fibrous degeneration of the walls of the intestine. The origin of the strictures was not discovered, but the author is of the opinion that the anæmia was caused by the resorption of toxins formed in the stagnating contents of the intestine; in another case severe anæmia seemed to have been provoked by the decomposition of a large dead bothriocephalus, while living animals of this kind ordinarily do not have this effect.

Norway.

DR. F. LEVISON,
REFERENT FOR DEN DANSK LITTERATUR VEDRØRENDE: ALMINDELIG MEDICINSK PATHOLOGI OG THERAPI, DERI INDBEFATTET, NERVE- OG SINDSSYGDOMME, PÆDIATRIE, OBSTETRIK, GYNÆKOLOGI, HYGIEINE, DEMOGRAPHI, RETSMEDICIN, PATHOLOGISK, ANATOMI, BAKTERIOLOGI.

Alle medicinske Böger, Disputatser, Monographier, Tidsskrifter, etc., der adkomme i Danmark bedes sendt til

DR. LEVISON,
Norrevoldgade, 13,
Köbenhavn.

Artificial Labor in Contracted Pelvis.—VOGT gives the results of 24 cases of artificial labor in 16 multipara. (*Norsk. Mag. f. Lägevidenskaben*, p. 349, 1895.) These patients had previously borne altogether 64 children, 39 of which were dead-born. The conjugate diameter of the pelvis varied from 9.3 to 12 centimetres. In delivering 30 of the children an operation of some kind had been necessary in order to complete the labor, the infant mortality being 24 per cent. Krause's method was the one generally employed, sometimes combined with tamponade of the cervix and uterus with iodoform gauze and intra-uterine injections of glycerin.

Sterility.—VEDELER (*Norsk. Mag. f. Lägevidenskaben*, p. 380, 1895), from a study of 310 cases of sterility, concluded that the fault was imputable to the husband in 211 cases. In 196 cases it was due to inflammatory conditions,—probably gonorrhœal. Syphilis was the cause in 3 cases, azospermia in 4 cases, persistence of the hymen in 4 cases, and impotence of the husband in 1 case. In 3 instances the woman became pregnant by another man. In only 92 cases could the sterility be attributed to the woman, as due to diseases or malformations of her genital organs.

Pathology of Ileus.—JOHANN NICOLAYSEN has studied the etiology and pathology of ileus in 30 cases, with special reference to peritoneal adhesions and disturbed motility of the intestinal wall. (*Norsk. Mag. f. Lägevidenskaben*, June, 1895. Supplement.) From his experiments it appears that purely mechanical flexion of the intestine may give rise to symptoms of ileus without the presence of paralysis in the twisted portion, and that pseudostrangulation may follow the reposition of a gangrenous loop without giving rise to peritoneal infection. The examination of 6 cases of volvulus showed the importance of dilatation and paralysis of the intestine in the production of this form of occlusion. In 2 cases of obstinate coprostasis it was seen that renal calculi had caused complete obstruction for a considerable period. The fæcal matters above the point of strangulation ordinarily contain but one or two species of microbes, the matter being sometimes toxic on account of the toxins and gas (SH_2) which it contains. Cases of ileus complicated by intestinal gangrene were characterized by great prostration and a pulse of over 100, while those without gangrene showed a pulse about the average. When gangrene was not present the peritoneum was sterile or contained only a small quantity of non-virulent microbes, while in cases with gangrene the staphylococcus aureus or the bacterium coli was present. The author succeeded in vaccinating guinea-pigs and rabbits against the latter bacillus, and induced artificial strangulation in animals, the condition being borne for from ten to twenty-four hours before death ensued.

Russia.

DR. J. DRZEWIECKI,

РЕДАКТОР-КОРРЕСПОНДЕНТ из области русской литературы, касающейся: Общей медицины и терапіи, педіатріи, акушерства, гинекологіи, ларингологіи, отологіи, гигіены, лекографіи, судебной медицины, гистологіи, бактеріологіи, анатоміи и физіологіи.

Всѣ періодическія, медицинскія изданія, сочиненія, стат'и, монографіи и т д., изданныя на русском языкѣ и касающіяся вышепоименованныхъ предметовъ должны быт' адресованы на имя

ДРА ДРЖЕВЕЦКАГО.

87 Краковское Предмѣст'е,

Варшава.

Excretion of Mercury Through the Sweat-Glands.—The absence of positive information upon this subject in medical literature led MIRONOVITCH to make a series of experiments upon a number of patients to whom mercury was being administered in some form (*Med. Oboz.*, No. 12, 1895). A Roman bath at 75° to 80° C. (167° to 176° F.) was used for twenty minutes to induce perspiration, and for control examination equal quantities of sweat and urine. The author concludes that the elimination of the drug through the perspiration is much greater than has hitherto been supposed. A relatively larger quantity was excreted by the sweat than by the urine, but only in cases in which mercury was introduced into the system by friction a short time before. This the author explains by the retention of the drug in the sudoriparous glands of the skin, friction causing it to be pushed into these glands before it has time to enter the blood. The quantity was the same in the sweat and urine of patients treated by injections.

He expresses the opinion that when it is necessary to relieve the

economy of an excess of mercury, it can be effected through increased perspiration.

Alcohol Poisoning and Strychnine.—RUNKEWITCH, in the pharmacological laboratory of Professor Burzynski, of Tomsk, studied the action of strychnine in alcohol poisoning, finding that the drug rapidly and distinctly augments the excitability of the motor area of the cortical substance of the brain, previously depressed by alcohol. In this manner it raises the action of the depressed respiratory centres and augments the blood-pressure during alcoholic narcosis. It affects the temperature only in doses large enough to cause tetanus. The experiments of the author were made upon animals, and further investigations are necessary in order to determine whether his conclusions apply equally to man.

Action of Morphine and Chloroform upon Leucocytosis.—A. POPOFF, from experiments on 38 dogs, concludes (*Inaug. Diss.*, St. Petersburg, 1895) that morphine causes a gradual though slight increase of the white corpuscles without previously diminishing them. For this reason it is a suitable hypnotic for animals. The action of chloroform is similar, but more pronounced. Diminution of the white corpuscles begins only on the third day, the number of leucocytes of all shapes increasing until the third day, when the number of multinuclear cells diminishes and that of the young cells increases. Under inhalations of chloroform the activity of the white corpuscles is disturbed and slackened, but on awakening from narcosis the number is increased. Transfusion of blood from a narcotized into a normal animal always increases the number of white corpuscles in the latter.

Strychnine in Pregnancy.—OLENYN is favorably impressed with this remedy, having successfully used it in sixteen cases of weak labor-pains, in doses of 0.002 to 0.0025 gramme ($\frac{1}{32}$ to $\frac{1}{25}$ grain) twice daily, at intervals, during the last six or eight weeks of pregnancy. (*Protocol of the Medical Society of Tombow* for 1894.) Four of his cases were anæmic primiparæ from 19 to 32 years of age, with weak muscles; three were multiparæ under 30 years, with habitual feeble labor-pains; four suffered from chronic metritis and had been pregnant at intervals of from three to twelve years; one patient had a small uterine fibroid; two had a flabby uterus and relaxed abdominal walls; one had tertiary syphilis and general debility, and another diseased appendages with hysteria. In two primiparæ the forceps had to be used, and in one the child was dead; but in all the other cases delivery was rapid and regular and the children lived. The third stage lasted from ten to twenty minutes and post-partum contraction of the uterus was excellent.

Influence of Alkaline Mineral Waters on the Blood.—BOURMIN (*Vratch*, No. 24, 1895) states that the alkalinity of the blood is increased by alkaline waters only after some days, and that, in order to induce such a condition in a short time, it is necessary to use one bottle of Vichy water daily. As soon as the use of the water is discontinued the blood returns to normal. Examination of the blood will, therefore, prove of value as indicating the necessity for continuing or abandoning a course of treatment by mineral waters.

Sweden.

DR. F. EKLUND,
Brefväxlande Medarbetare
för den
SVENSK MEDICINSK LITTERATUR.

Af alla i Sverge utkommande medicinska tidskrifter, bocker, afhandligar, monographier a. s. v. torde ett exemplar benäget öfversändas till

DR. ABRAHAM
FREDRIK EKLUND,
Sibyllegatan, 8 A,
Stockholm.

Puncture in Pleuritic Effusion.—I. SVENSON (*Hygiea*, lvii, p. 122), in discussing this subject, dwells on the necessity of preventing air from entering the pleural cavity, failure to do this accounting for many of the unfortunate sequelæ so frequently noted. He describes a trocar invented by himself which obviates this danger, and which combines the advantages of enabling the operator to thoroughly wash out the cavity, to remove any clots, etc., without drawing out the instrument, and also of being easily sterilized by boiling. The author is in favor of early puncture and does not advise waiting for the chances of resorption. He prefers thoracotomy to any other operation, as being more safe and reliable, and especially recommends it in cases of fetid, ichorous empyema. He usually removes a portion of the contents of the pleural cavity before operation, in order to diminish the danger to the heart during anæsthesia, and then proceeds to perform the operation as speedily as possible, in order to consume but a small quantity of chloroform, and thus lessen the ill effects upon the kidneys, perhaps already damaged. Bülau's method, puncture with a trocar and permanent drainage by aspiration, is a most advantageous one in fresh cases of empyema without complications in young subjects. Neither healing nor recovery follows its employment, however, in cases in which the lung has lost the power of expansion, in pyopneumothorax, pulmonary fistula, or where large masses of precipitated fibrin are present. While it is not contraindicated in cases of metapneumonic empyema, the fibrinous adhesions between the lung and thoracic wall may prove an obstacle in the aspiration by drainage. The greater mortality observed after thoracotomy is attributed by the author to the fact that Bülau's operation is usually performed in fresh and suitable cases, whereas thoracotomy is generally a last resort, in which the prognosis is not as favorable.

Pregnancy with Cancer of the Uterus and Ovary.—E. ALIN (*Hygiea*, lvii, No. 7) describes the case of a married woman, aged 22 years, who for three weeks showed symptoms of generalized peritonitis with beginning ileus. The fœtus seemed to be viable. Operation became necessary and showed a tumor in the lesser pelvis, behind the uterus, the size of a child's head. It was removed by tearing away the adhesions to the neighboring parts, its contents, decomposed and grayish-brown in color, partially escaping into the abdominal cavity. The surface of the wound was rough and knotty. The pedicle, short and curved upon itself, was as thick as two fingers. It originated in a portion of the tumor as large as a hen's egg, to the left of the uterus, and was firmly adherent to the sigmoid flexure, the latter being greatly compressed. The capsule of the tumor, the point of departure of which was undoubtedly the left ovary, was fibrous and a little more than one centimetre in thickness. The left wall of the uterus contained a neoplasm the size of a child's head, extending from the point of

departure of the other tumor to the fundus and toward the median line, occupying half the width of the uterus, and distinguishable from the surrounding parts by its yellowish-red color. The mass of the tumor was separated from the uterine cavity by a layer of muscle one centimetre thick. Twenty-four hours after operation a macerated fœtus forty-seven centimetres long was born almost naturally, presenting by the buttocks. The placenta, occupying the right uterine wall, was removed by expression. Collapse occurred, followed by death, and at the post-mortem examination it was seen that the cancer of the left ovary had extended directly into the uterus.

Clinical Notes.

The Blood at High Altitudes.—As Lazarus states (*Médecine Moderne*, August 3, 1895), the opinions as to the diminished pressure of the air on mountains are widely divergent. Some affirm that malaise and palpitation occur at an altitude of 4000 metres, while others feel no particular discomfort at a height of 9000 metres. P. Bert, in 1878, affirmed that the physical element of pressure was inferior, in point of importance, to the chemical element of diminished oxygen. This view was also adopted by Fraenkel and Gebhard, while Lazarus is of the opinion that both elements have an equal influence, though it must be admitted that all men do not feel this influence to the same degree. The prospect of building a railway on the Jungfrau has given a renewed interest to the question in Switzerland and Germany, and Professor Kronecker, who was requested to ascertain what effects on the health would be experienced if the journey from the foot to the summit of the mountain were made in fifteen minutes, replied in a manner favorable to the project. He states that only a certain number of individuals are inconvenienced by rapid ascension in a railway-car, and then only for a short time.

Lazarus concludes that an altitude of 4000 or 5000 metres may be safely supported by healthy persons, but that dangerous symptoms may supervene in cardiac subjects.

Captain Gross remarks that in balloon ascensions the temperature of the air has not been sufficiently considered. Healthy men have experienced no serious symptoms until an altitude of 5000 metres has been reached. Any physical effort in such altitudes, however, may cause mortal accidents. He himself experienced dangerous symptoms on trying to lift a sack of sand when at a height of 5000 metres, whereas he had previously ascended to a height of 8000 metres without any trouble. At the height of 4000 metres he had felt some palpitation, at 6000 metres a rather agreeable sensation of lassitude, while at 7000 metres he had no longer sufficient energy to draw his furs about him on account of the great cold at this height.

Loewy believes that physical exercise is possible on mountains or in

balloons, provided respiration is deep; and he attributes the symptoms experienced by Gross to the fact that the position taken to lift the sand-bag restricted the breathing movements.

Many observers have noted that the number of red corpuscles of the blood increases in high altitudes, the increase being relatively large within twenty-four to thirty-six hours. The cause of this modification has been attributed to the diminution of oxygen. SELLIER and JOLYET, of Paris (*Revue Scientifique*, June 15, 1895), have recently attempted to prove that the hyperglobulia of high altitudes is not due to pressure of the respired air, but to diminished tension of the oxygen in the mixture of oxygen and nitrogen respired. FRAENKEL and GEBHARD, however, have found, from experiments on animals in a pneumatic cabinet with the same pressure of air as at the summit of Mont Blanc (4900 metres), that the blood becomes saturated with oxygen.

GRAWITZ (*Berliner med. Woch.*, August 19, 1895) attributes the condition to another meteorological factor, viz., an increased emission of water in the form of vapor from the organism. From meteorological researches it is known that with increasing altitude the pressure of vapor diminishes much more rapidly than the atmospheric pressure, causing the organism to give out more vapor, leading to such symptoms as thirst, concentrated urine, dryness and cracking of the skin, etc. Grawitz brings to the support of his theory some experiments upon rabbits. These he placed under glass globes, submitting them to a notable diminution of atmospheric pressure. The increase of red corpuscles was found to be always in direct proportion to the amount of water lost,—an amount regained within twenty-four hours when the animal was replaced in normal conditions.

In the discussion of Grawitz's paper, ZUNTZ declined to accept this theory, claiming that if the hyperglobulia depend on a diminished amount of water in the blood, such diminution would also occur in the tissues, causing a loss of 7 or 8 kilogrammes (14 or 16 pounds) in body-weight. This, however, has not been observed in any case.

A New Method of Stomach-Washing.—DR. JOHN T. PITKIN, of Buffalo, describes, in the *Buffalo Medical Journal* for October, a recurrent method of his own for stomach-washing, which he much prefers to the ordinary stomach-tube with funnel attachments. He introduces two small-sized, semi-elastic pieces of white rubber tubing, a yard in length, into the pharynx, the patient being in the recumbent position and making frequent efforts at deglutition, intermitting with long inspirations. The physician meanwhile gently, but persistently, presses the tubes downward until half their length has been swallowed. If necessary, a preliminary application of a 10-per-cent. cocaine solution may be made to allay reflex irritability. The tubes being inserted, a common bulb syringe is attached to the distal end of one tube and from 1 to 3 pints ($\frac{1}{2}$ to $1\frac{1}{2}$ litres) of water, as hot as can be borne by the hand, slowly and carefully injected. The syringe is then removed and the end of the tube placed in a proper receptacle, when the contents of the stomach will be siphoned out. More fluid can in the meantime be injected through the second tube until only clear water is discharged

from the stomach. Should the tube of egress become clogged the currents may be reversed or the patient may make a deep inspiration. If the mucous accumulations are too viscid to escape rapidly, liquor calcis may be added to the water in the proportion of 1 to 3.

Angina Pectoris Due to Tobacco.—PROFESSOR POTAIN points out (*Journal de Médecine de Paris*, October 6, 1895) certain peculiarities enabling the physician to diagnose the angina pectoris caused by the excessive use of tobacco. In true angina pectoris from a coronary lesion, the attack is due to increased work of the heart; the pain is of a tearing, burning character, and is substernal. In tobacco-angina the attack is spontaneous, without any effort on the part of the heart, and lasts several hours. The pain is often substernal, but also frequently præcordial; it is as intense as in true angina pectoris, but there is a feeling of dilatation. This rule, although not absolute, will be found to apply in the majority of cases, and it will also be observed that whereas in true angina pectoris the least movement will increase the attack, that due to tobacco is in nowise influenced by movement.

Recent Suggestions in Therapeutics.

Bronchitis, Herpetic.—According to LANCEREAUX (*Gaz. des Hôp.*, September 24, 1895) there is but one remedy which will calm the cough of herpetic individuals,—a cough occurring spasmodically and preceded by a tickling sensation in the throat. This remedy is *sulphate of quinine*, in doses of 1½ to 2 grammes (23¼ to 31 grains) for adults, and 0.40 to 0.75 gramme (6 to 12 grains) for children, taken in two or three doses half an hour apart. To obtain a satisfactory result it is essential that the patient feel buzzing in the ears, vertigo, headache, etc. This result is ordinarily apparent in three or four days, but the treatment must be continued during the same space of time in order to prevent the return of the cough.

Bronchitis, Subacute.— ℞ *Ammonium chloride*, *sodium iodide*, of each 3 drachms (12 grammes); *syrup of Tolu*, *syrup of senega*, of each 1½ fluidounces (50 grammes). If a spasmodic element be present, add *sodium iodide*, 2½ grains (0.16 gramme) to each dose. (ESHNER, *Philadelphia Polyclinic*, September 21, 1895.)

Dry Seborrhœa of the Scalp.—℞ *Beta-naphthol*, 0.30 gramme (4½ grains); *camphor*, *resorcin*, each 0.20 gramme (3 grains); *sulphur precipitate*, 3 grammes (46 grains); *pure vaselin*, 20 grammes (5 drachms). Use as an ointment twice a week, removing any excess with a handkerchief. Next morning clean the head with a little *petroleum ether*, or, if too irritating, use the following: *Liquid ammonia*, 10 grammes (2½ fluidrachms); *rum*, 40 grammes (1¼ fluidounces); *tincture of quinine*, *tincture of rosemary*, each 30 gammes (1 fluidounce); *walnut-leaf in-*

fusion, 200 grammes (6½ fluidounces). If the seborrhœa is very oily, apply the following lotion three times a week: *Sulphur*, 25 grammes (6½ drachms); *camphorated alcohol*, 50 grammes (1½ fluidounces); *pure glycerin*, 5 grammes (1¼ fluidrachms); *distilled water*, 200 grammes (6½ fluidounces. (BROCQ, *Jour. de Méd et de Chir. prat.*, September 10, 1895.)

Hay Fever.—℞ *Mentholis*, 20 grains (1.3 grammes); *olei amyg. dulcis.*, 2 drachms (8 grammes); *acidi carbolici*, 10 minims (0.65 gramme); *cocain. hydrochlor.*, 6 grains (0.39 gramme); *ung. zinci oxidi*, ½ ounce (16 grammes). Sig.: Apply thoroughly to the nostrils on cotton attached to a tooth-pick. (FREDERICK G. SMITH, Somerville, Mass., *Medical Record*, October 5, 1895.)

Izal.—DR. SHERIDAN DELÉPINE, of Manchester (*Medical Chronicle*, September, 1895), from a series of experiments with this agent, comes to the conclusion that when diluted with 100 or even 200 parts of water it is a powerful and reliable antiseptic when contact of a sufficient length of time is secured. As an antiseptic it is more powerful than carbolic acid, and, if it be remembered that it causes very little irritation of living tissues, that in moderate doses it is not poisonous, and that, practically speaking, it is not volatile, there can be little doubt, in his opinion, as to the immense advantages which izal possesses over carbolic acid in many directions.

Mercury in Heart Disease.—WILLIAM MURRAY, of Durham, Eng. (*Lancet*, September 28, 1895), is convinced from repeated observation that mercury possesses a value far beyond its supposed alterative action, and that it tells upon the heart itself. Its special benefits are exercised in cases of dilated and hypertrophied heart. By means of it the "thready," weak, rapid, and irregular pulse is made full, soft, regular, and slow, with manifest relief of such symptoms as dyspnœa, pectoral weight and tightness, and sensations of faintness. The "angina sine dolore" is often marvelously relieved and removed by 2 or 3 grains of blue pill three times a day, and the severe forms of "angina pectoris" not unfrequently disappear under its influence. While the nitrites, nitroglycerin, etc., afford temporay relief, this remedy is much more permanent in its effects. "Nor need I say that to give digitalis a fair chance it is absolutely necessary to pave its way by preliminary doses of mercury and to foster its action by repeated doses. Many of the cases where digitalis, etc, fail, or seem to fail by supposed accumulation depend on this, that we are giving the digitalis without the blue pill or calomel. The same is true of iron and digitalis. Mercury should be given until the portal system is drained and a slow, soft, regular, and effectual pulse is produced, when digitalis or strophanthus can be used as cardiac tonics, followed by iron and digitalis."

Pambotano in Malaria.—DR. CRESPIN, of Algiers (*Bull. Gén. de Thér.*, August 15, 1895), has tried *pambotano* (*Callandra Houstoni*) in a great many cases of malarial disease and finds that it is often successful when

Pambotano in Malaria *(continued)*.

quinine and other remedies entirely fail. It is especially successful in the quotidian, intermittent, and simple continued forms, and also in chronic malaria; but in bilious, pernicious, and neuralgic attacks it gives no marked result. In most cases it caused an increase of appetite, the drug appearing to be a powerful stomachic, superior in this respect to quinine. *Pambotano* appears to have no specific effect on the malarial phenomena, but apparently acts by improving the general health, thus favoring the elimination of infectious elements by the skin. This discharge is almost entirely cutaneous, explaining the success of the remedy in various infectious diseases, as influenza and typhoid fever. The author used a decoction of the root or an elixir, giving 80 grammes (2½ ounces) of the former, in eight doses within twenty-four hours, to an adult, and half that dose to a child.

Monographs Received.

The editor acknowledges, with thanks, the receipt of the following monographs:—

Hysterical Amblyopia and Amaurosis, by **J. Arthur Booth**, New York, 1895.——The Treatment of Laryngeal Tuberculosis, by **Robert Levy**, Denver, Col., 1895.——Cystic Tumors of the Vaginal Vault, by **Frederick Holme Wiggin**, New York, 1895.——Epidemic Catarrhal Fever as Found in Children, by **W. C. Hollopeter**, Philadelphia.——The Infiltration Method of Local Anæsthesia in Genito-Urinary Surgery, by **Bransford Lewis**, St. Louis, Mo., 1895.——Clinique des Maladies du Nez, de la Gorge, du Larynx, et des Oreilles (Statistique), par **Hamon du Fougeray**, Paris, 1895.——A New Mastoid Retractor, by **Max Thorner**, Cincinnati, O., 1895.——Hæmatoblasts and Blood-Platelets, by **M. L. Holbrook**, New York, 1895.——Dell' Influenza Dell' Ittiolo Sul Ricambio Dell' N., Dell's E. Del P., del **Angelo Ceconi**, Padova, Italia.——De l'emploi de l'ichthyol dans le traitement des tumeurs fibreuses adhérentes, par **Jules Cheron**, Paris, 1895.——Die Behandlung der Lungentuberculose mit Ichthyol, von **L. Guido Scarpa**, Turin, 1895.——Applicazioni Cliniche Dello Siero Anti-Difterico-dal **Luigi Mazzotti** e dal **Luigi Bacchi**, Bologna, 1895.——Ichthyol bei Epididymitis Gonorrhoica, von **S. Maylander**, Budapest, 1895.——Corso Complementare di Oto-Rino-Laringologia della R. Universita di Pisa, del **Vittorio Grazzi**, Pisa, 1895.——Pyosalpinx, by **Louis Frank**, Louisville, Ky.——Malignant Endocarditis, by **John A. Robison**, Chicago, Ill.——Device to Secure the Trendelenburg Posture, by **William A. Edwards**, San Diego, Cal., 1895.——State Boards of Medical Examiners *vs.* Medical Colleges, by **Thomas H. Hawkins**, Denver, Col.——Method of Resuscitation from Electric Shock, by **F. J. Gibbons**, Syracuse, N. Y., 1895.——Medical Terminology, by **P. J. McCourt**, New York, 1895.——Herniotomy; Osteotomy, by **Samuel E. Milliken**, New York, 1895.——Perforation in Enteric Fever, by **Frederick Holme Wiggin**, New York, 1895.——Cirrhosis of the Liver in Childhood, by **Wm. A. Edwards**, San Diego, Cal., 1895.——Infantile Scorbutus, by **Wm. C. Hollopeter**, Philadelphia, 1895.

☞ ***Any journals, exchanges, reprints, monographs, or books not sent directly to the editorial office, 28 rue de Madrid, Paris, will not receive attention either in the "Annual" or the "Universal Medical Journal."***

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OF THE

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CHARLES E. SAJOUS, M.D., EDITOR-IN-CHIEF,

28 RUE DE MADRID, PARIS, FRANCE.

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Alle Bücher, Schriften, Aufsätze, Abhandlungen, etc., solten d. Haupte-Redacteur (franco) zugesandt werden. No. 28, RUE DE MADRID, PARIS, FRANCE.

(End of Editorial Department of Journal for November, 1895.)

DIPHTHERIA ANTITOXIN.

In these days of modern medicine, experiments have followed experiments with a view to counteract the march of the deadly bacillus. Physicians the world over are alive to the importance of discovering some method or some preparation to rob diphtheria of its terror and lessen the terrible death-rate of this scourge of infantile life. The Antitoxin of Aronson is officially controlled by the German government through the Berlin Institute, which guarantees its purity and efficacy. Aronson's (from which the best results are obtained) is a highly-concentrated antitoxin from which all inert and noxious materials have been removed. Its preparation requires long periods of time, the greatest of care, the minutest scientific supervision, and elaborate and expensive apparatus. Dr. Baginsky, Professor of Pediatrics at the University of Berlin, gives the weightiest testimony in favor of the antitoxin treatment, and embodies his experience with this new remedial agent in his book "The Serum Treatment of Diphtheria," published by Hirschwald, Berlin, 1895. Dr. Otto Katz assists the professor in giving a complete history of all the cases treated from March 15, 1894, to March 15, 1895. In his more extensive work, "The Antitoxin Therapeutics of Diphtheria," Professor Baginsky reviews all the experience he has had with the new treatment, the total number being 525 cases treated with antitoxin.

The Thirteenth Congress of Internal Medicine was held in Munich in April, 1895, and was marked by a valuable debate on the Serum Therapy in Diphtheria. In the paper before us the most distinguished physicians at the congress took part in the debate, and all testified to the merits of "Diphtheria Antitoxin." Dr. Louis Fischer, in an article on the antitoxin treatment of diphtheria (*American Journal of Medical Sciences*, January, 1895), records some cases of his own treatment by injection. Dr. Fischer is emphatic in stating that it is perfectly safe. The cases treated by Dr. Fischer at the Municipal Hospital of Philadelphia were examined bacteriologically by Dr. D. Braden Kyle. Dr. G. C. Crandall, St. Louis, Mo., has compiled a *résumé* of the statistics of the Diphtheria Serum Therapy from the library of The Royal College of Surgeons of England. In closing this subject we are forced to believe that there is not the remotest doubt that the mortality is much lower than before the treatment was inaugurated.

Reliable and active preparations of antitoxin are put up in clear liquid form, in small, sealed vials, having an official guarantee of the antitoxic value, concentration, and aseptic condition of the preparation. Such is the preparation known as Schering's (Aronson's) Diphtheria Antitoxin.

LACTOPHENIN.

This drug is claimed to be a specific for typhoid fever. Dr. Jaquet, of Basel, says it is the most remarkable of all the new antipyretics. This new antipyretic and analgesic is indorsed by such eminent clinicians as Dr. G. von Roth, of Vienna; Prof. R. von Jaksch, of Prague; Dr. Landowski, of Paris; Professor Schmiedeberg, of Strassburg, and others.

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Selections from Society Proceedings.

AUSTRIA.

GESELLSCHAFT DER AERZTE IN WIEN.

Nature and Treatment of Gout.—DR. RUDOLF KOLISCH, in a paper on this subject, called attention to the want of a physiological basis for the theories of gout currently accepted, and which attribute to a disturbance in uric-acid formation a predominating rôle in the etiology of the disease. In his opinion, the uric-acid diathesis should be classed among the other conditions accompanying an increase of alloxuric substances in the urine. As long as the kidneys, which secrete uric acid, are healthy, the products of the destruction of nuclein are eliminated with the uric acid. In diseases of the kidneys the elimination of uric acid is interfered with and is replaced by the elimination of the alloxur bases. It appears, from the researches of Levison, that there is an intimate relation between true gout and certain forms of renal atrophy. As in the renal disease often observed in lead poisoning, the gouty kidney is, in the opinion of Dr. Kolisch, produced by the toxic action of alloxur bases, which constitute the poison of gout. As long as the kidneys are normal, the excretion of uric acid is increased in the uric-acid diathesis; but when the organs become diseased, uric acid is at first eliminated in normal quantities and the alloxuric substances in excess; while in a more advanced stage the excretion of uric acid is diminished and that of the alloxuric substances still more increased. Gout is thus an exaggerated destruction of nuclein, the derivatives of which are eliminated in the form of uric acid when the kidneys are healthy and in the form of alloxuric substances when the kidneys are sclerosed. It is essentially, therefore, an auto-intoxication. Acute attacks result from a sudden destruction of nuclein and an overcharging of the organism with

the products of its decomposition, and cannot really be regarded as favorable. Early diagnosis of gout may be made by searching for the alloxur bases in the urine and the so-called perinuclear basophilia in the blood. As regards treatment, there is no specific for the disease; but the patient must be made to avoid all things likely to injure the kidneys or favor the decomposition of nuclein. Albuminous foods need not be entirely forbidden, and boiled meats, milk, eggs, and fat may be allowed.

WIENER MEDICINISCHER CLUB.

New Method of Estimating Mercury in the Urine.—DR. ADOLF JOLLES presented the following method of making a quantitative analysis of the urine for mercury: Powdered gold, specially prepared in order to give it the highest possible amalgamating power, is added in the proportion of 2 grammes (31 grains) to from 100 to 300 cubic centimetres (3¼ to 9½ fluidounces) of urine and from 1 to 3 cubic centimetres (15½ to 46 minims) of concentrated hydrochloric acid. The mixture is heated and from 2 to 3 centimetres (31 to 46 minims) of chloride of tin, freshly prepared, is added. If a flaky precipitate of hydrated oxide of tin is produced, too little hydrochloric acid has been used,—an error which is easily corrected. The liquid is heated to 70° or 80° C. (158° or 178° F.), and from 30 to 50 cubic centimetres (1 to 1½ fluidounces) of the chloride-of-tin solution added, stirring in the meanwhile. The mixture is heated and stirred for five minutes longer and left to stand for several minutes. The liquid above the amalgam is poured out and the latter washed several times with distilled water until the reaction of chlorine is no longer obtained from the water. Three or four drops of a hot concentrated solution of nitric acid is added to the purified amalgam, several drops of water poured on, and finally an equal quantity of chloride of tin. The amalgam and the gold are then weighed separately, after having removed the mercury. According to Dr. Jolles, the test is not as costly as might appear, as the gold can be used for a number of analyses.

FRANCE.

CONGRÈS FRANÇAIS DE MÉDECINE INTERNE, BORDEAUX.

Relation between the Intestine and the Liver in Pathological Conditions.—M. V. HANOT, of Paris, in a complete exposition of the pathology of the liver, drawn from his own experience and the researches of his pupils, offered the following conclusions: Physiologically, intimate relations exist between the liver and the intestines, through the nerves and the circulation. The liver is one of the fundamental wheels of the general nutrition, feeding all organic activity and defending against poisons. By creating the bile it maintains the nutritive equilibrium of the intestine, neutralizing the poisons which reach it or form in it during its action, and also aiding in the special work of digestion. The physiological services rendered to the liver by the intestine are more restricted; it appears to be the vestibule of all toxic and

infectious agents, alimentary poisons such as alcohol, digestive poisons such as acetic, lactic, or butyric acid, and microbes and their toxins. An injurious influence is exercised upon the liver by the intestine only when the former permits it. It is from these relations between the two organs that the doctrine of intestinal antisepsis springs; and it will be easily understood that the term must not mean merely a direct action exercised on the intestine, but also an indirect action exercised on the liver. While the intestinal poisons are neutralized in the intestine itself, the antitoxic power of the liver must be maintained or strengthened, in order that it may contribute its part toward the destruction of the intestinal poisons, and at the same time defend itself from the poisons which enter it by other channels. In short, intestinal antisepsis is not really efficacious unless it is hepato-intestinal.

In the discussion of this paper, TEISSIER described some experiments made with Guinard upon dogs, which demonstrated that certain microbian toxins, probably those with great diastasic power, when introduced through the portal vein, acquired an increased virulence in the liver, and, although retained there for a certain time, produced symptoms much more rapidly fatal than if the same toxins had been introduced in equal amounts into the peripheral venous system. Contrary to what has hitherto been supposed, therefore, the liver would appear to be capable, under certain circumstances, of aggravating the action of such toxins as those of the pneumobacillus and the diphtheria bacillus, by increasing their virulence and not by the addition of symptoms due to the destruction of the hepatic cells, in which no marked alterations could be observed. This new function of the liver would explain the suddenness and gravity of certain intestinal affections, as dysentery and cholera.

Tuberculous Pyoperihepatitis in the Adult.—M. MONNIER, of Nantes, described the case of a man aged 41 years, of alcoholic habits, and whose only illness had been an attack of influenza in 1888. There were two distinct phases in the symptomatology of the case. During the first months following his admission to the hospital in March, 1893, there were only gastro-intestinal symptoms; from August on signs of diaphragmatic pleurisy were noted. Death occurred on the 20th of September, and at the necropsy about 300 grammes (9½ ounces) of ascitic fluid were found in the peritoneum, which was dotted with tuberculous granulations involving the large intestine, the loops of which were agglutinated. Between the mass formed by the upper part of the jejunum and the liver was a pocket filled with pus, and another between the diaphragm and the median line of the upper edge of the liver. Section showed three distinct abscesses of the liver, and microscopical examination revealed the tuberculous nature of the angiocholitis. The author regarded the case as the only one of tuberculous pyoperihepatitis in the adult recorded in medical literature.

Microbic Origin of Gall-Stones.—LÉTIENNE, of Paris, describes a case of biliary lithiasis in which Terrier performed cholecystostomy. The gall-bladder showed the anatomical lesions common to old calculous cholecystitis, but there was also a parietal diverticulum containing calcareous

concretions; there were twenty-one calculi in the cavity of the bladder and some calcareous concretions in its walls. Bacteriological examination of these portions revealed the presence of the bacterium coli and streptococcus in the bile and the bacterium coli in the parietal concretions. The case seems to the author to support the theory of a parasitic origin of gall-stones, and to show that the bacterium coli, according to its habitat, may cause transformations in the humors of the organism, leading to the formation of concretions differing chemically from one another. Biliary and parietal calculi, though of heterogeneous constitution, may thus be attributed to a microbic origin.

Infectious Hypothermic Icterus.—AUCHÉ and COYNE, of Bordeaux, observed a case confirming the assertion of Hanot, that there was a form of serious hypothermic icterus due to the bacterium coli. The patient was a child 10 years of age, a deaf-mute, who died from typical icterus supervening without apparent cause and not accompanied by fever. At the autopsy the lesions of acute yellow atrophy of the liver were revealed, with cholecystitis and angiocholitis, involving even the smallest extra-lobular canaliculi. The coli bacillus was present in large numbers in the bile-ducts and some few in the spleen. The authors believe the case to have been one of angiocholitis caused by the coli bacillus, which, leaving the duodenum, gradually invaded the biliary canaliculi, reaching the hepatic parenchyma and causing acute atrophy and symptoms of icterus.

CONGRÈS FRANÇAIS DE CHIRURGIE.

Statistics of Hernia.—PROFESSOR BERGER, of the Paris Faculty, presented the result of his examination of some 10,000 patients who applied for trusses at the Bureau Central from February 4, 1881, to August 11, 1884. The information thus gathered differs materially, in many respects, from that currently met with in standard works. The applicants consisted of 7433 males and 2534 females (or 3 males to 1 female). Of the males of all ages affected with simple or multiple hernia 96 per cent. had the inguinal variety. Of 6220 herniæ in the male, 4526 were double inguinal and 1042 simple inguinal (or 4.34 double to 1 single). This is in direct contradiction to all known statistics and goes to prove that, in the immense majority of cases, inguinal hernia is a double process pursuing a synchronous or successive evolution on the two sides of the body in the same individual. Right inguinal herniæ are to left as 1.46 to 1. In bilateral inguinal hernia the right and left swellings are equal in volume to 42.2 per cent. in adults and 65.03 per cent. in adolescents; when irregularity exists the right is generally larger than the left. Many cases of budding (small) hernia escape observation; so much so that double hernia is even more common than would appear from the above figures. It is impossible in every case to assert the congenital origin of a hernia. In only 479 instances (216 above and 263 below 15 years, 166 being complicated with testicular ectopia and 48 with other congenital malformations) was Professor Berger able to do this. The right side offers a manifest predisposition for the congenital

form, which is very rarely bilateral. The funicular variety (Birkett's "hernia into the funicular portion of the vaginal process of the peritoneum"), which is very frequent, is indistinguishable from acquired hernia. There are no certain means of distinguishing in the living subject direct inguinal from external oblique hernia. In females simple or double inguinal hernia alone, or associated with other varieties, occurs in 44.6 per cent.; the simple is about thrice more common than the double in infancy, but only twice as frequent in adolescence and maturity. Femoral hernia is rare in hernial males (6.6 per cent.), and it is, in the majority of instances, associated with other varieties,—almost invariably the inguinal. Double is about as frequent as simple femoral hernia; right femoral is rather more commonly met with than the left. In females only 37.1 per cent. of hernial subjects have femoral hernia; crural hernia in females is, therefore, less common than inguinal hernia (1 to 1.35). In a certain number of cases the crural hernia escapes directly in front of the femoral vessels. The association of an inguinal hernia on one side, with a femoral hernia on the other, is sufficiently common, especially in the male (most commonly right femoral with left inguinal). Professor Berger has met with 207 examples in the male and only 19 in the female of uni- or bi- lateral co-existence of femoral and inguinal hernia. The most frequent combination is inguinal and femoral on one side with inguinal on the other (69 cases). Of herniæ in the male, 5.46 per cent. are umbilical; in the female, 27.34 per cent. Above 15 years of age umbilical hernia in the male is almost always associated with other varieties (119 cases out of 134); below that age it co-exists with single or bilateral inguinal hernia in rather less than half the cases. In the woman umbilical hernia is invariably unaccompanied with other varieties. In the infant of either sex it is frequently associated with subumbilical eventration. Hernia through the linea alba and epigastric hernia are more commonly met with than is generally believed. Of the total number of herniæ, they represent 1.37 per cent. (Macready's figures are 0.096 per cent.). They are much more common in the male than in the female; they are sometimes multiple (Professor Berger has seen four superposed herniæ through the linea alba) and seem to be the remains of the aplasia of the linea alba which constitutes in the infant subumbilical eventration. Twenty-nine laparoceles in the female, and only 9 in the male, 1 case of obturator hernia, 2 of lumbar hernia, 4 hypogastric and 4 cicatricial herniæ make up, with the preceding, 13,488 herniæ noted in 7433 males of all ages; 2534 female subjects furnished only 3317 herniæ. The proportion of herniæ to the subjects of them are in the male sex 2 to 1, and in the female sex 1.3 to 1. Professor Berger calculates that in the Department of the Seine there is, for every 14.9 males, for every 44.7 females, and for every 22.3 of all ages and sexes, 1 affected with hernia. In the male the frequency of simple inguinal hernia, very marked in the first 5 years of life, especially for the right side, diminishes rapidly up to 30 years, then increases up to a second maximum at 55 years. Double inguinal hernia, rare in infancy, increases rapidly in frequency from 30 to 45 years, less rapidly from 45 to 65, and then decreases. Congenital inguinal hernia is extremely common during the

first 5 years of life; it then diminishes very rapidly in frequency, or is only seen associated with other varieties between 35 and 55 years. This is a proof that nearly all cases of congenital hernia disappear spontaneously or under the influence of a truss. The radical cure of these herniæ is, therefore, apart from exceptional cases, unjustifiable during the first 4 years of life. Femoral hernia, exceptional in the male children, in whom it always is simple, hardly begins to show itself toward the age of 30; its maximum of frequency is between 60 and 70 years. Simple umbilical hernia in the male is very common in the first year; from the fifth year onward it practically disappears. Associated with other varieties, however, it is seen in middle and especially in advanced life. Epigastric hernia, rare in the male child, is hardly seen until after the age of 30. Multiple herniæ are rare in the male child, less rare in adolescents, but frequent in adults, and especially in old men. In the female the dominant form in early years is umbilical, which is extremely common; it disappears almost entirely between 10 and 30, but becomes again more common after the latter period. Inguinal hernia increases in frequency between the ages of 5 and 30, and both it and the crural variety from the latter age up to 70, when both decrease rapidly. The majority of inguinal herniæ (in the male) appear first between 40 and 50 years of age (congenital herniæ are not counted). Left inguinal hernia appears later than right. Congenital inguinal hernia makes its appearance mostly very early in life; this may, however, be deferred to the first or second childhood, or even to puberty, or again to a later period. In the female inguinal hernia appears somewhat earlier than in the male (from 30 to 35 years). Femoral hernia appears most frequently in women between the ages of 35 and 45, in man between 40 and 45, the maximum of frequency in women corresponding, as for inguinal and a certain number of umbilical herniæ, to the period of sexual activity. Umbilical hernia is congenital, or appears during the first year in nearly all cases in males, and in the great majority in females. In woman, a large proportion appearing after 30 years, it is a question whether these subjects are not congenitally affected, and whether pregnancy has not been the aggravating cause. Professor Berger has discovered that the average age at which hernia first appears in individuals affected with multiple or double varieties (especially double inguinal) is much more advanced than is the case in the subjects of simple hernia. This would seem to prove that simple hernia is more often congenital in origin, whilst the double or multiple are acquired. The interval (very variable) between the appearance of two herniæ in the same subject is longer for congenital inguinal hernia than for all other varieties of hernia. In acquired inguinal and in double femoral herniæ the interval hardly exceeds ten years; in a good third of the cases the bilateral hernial development is simultaneous. Hereditary influence was noted in 2079 out of 7542 cases. This hereditary predisposition is especially homosexual (from father to son and from mother to daughter). In families in which the hernial heredity was noted, one in three, or even one in two members had hernia, thus demonstrating the existence of hernial families. The influence of occupation in the production of hernia is un-

doubted (manual labor and, also, work in the erect posture). Certain sedentary occupations requiring a forward inclination of the body and repeated efforts predispose particularly to hernia. Parturition favors hernia, as is shown by its enormous frequency in multiparæ. It is especially after labor, rather than during pregnancy, that hernia appears, although some already existing herniæ only then increase in volume. Diseases of the respiratory organs favor hernia; urinary affections and habitual constipation have hardly any influence. Amongst occasional causes unusual muscular effort whilst in a false position or while carrying a burden is prominent. Cicatricial hernia is, according to Professor Berger, rarely seen. Irreducible hernia is comparatively rare (one in twenty-eight); it is commoner in femoral than in inguinal, in umbilical and epigastric than in femoral, and more frequent in woman than in man. It is less commonly seen in hernia subjected to the pressure of a truss than in others. Functional troubles (colic, local pain) are observed in cases of voluminous and partially irreducible herniæ. Dyspeptic symptoms are very frequent in male subjects with epigastric and in female subjects with umbilical ruptures. Of 10,000 hernial subjects of all ages and both sexes 3.31 per cent. had suffered at one time or another from serious complications connected with the hernia. These complications were more frequent in the female (5.84 per cent.) than in the male (2.46 per cent.), in femoral hernia (6 45 per cent.) than in umbilical (1.91 per cent.) or inguinal (1.45 per cent.). Of these complications, strangulation (serious 250 cases, mild 43 cases) was the most common. The wearing of a truss appears to exercise no influence one way or the other in inducing the appearance of complications which are liable to recur. They are more frequent in old than in recent herniæ; they are more serious in woman than in man, in femoral than in other varieties. In more than one-half of the cases of strangulated femoral hernia in the woman kelotomy had to be resorted to. Thus, while females are much less liable to hernia than males, complications are more frequent, and these complications are more serious in their nature. This is an important point in life-assurance reports. Strangulated hernia, with or without operation, does not, however, appear to involve a high mortality (about 1 per cent.). There is, therefore, one condition without which the operation for the radical cure of hernia is unjustifiable, and that is its innocuousness.—*Lancet*, November 9, 1895.

GERMANY.

CONGRESS DER DEUTSCHEN DERMATOLOGISCHEN GESELLSCHAFT, GRATZ.

Pathological Anatomy of Pemphigus.—DR. EPPINGER, of Gratz, read a paper based on the examination of six cases, two of which were examples of pemphigus foliaceus. He found that the covering of the blebs was not always the same; the prickle layer, however, always perished, although sometimes undergoing degenerative changes. Changes in the epidermis in the neighborhood of the blebs with œdema of the skin were always present. The blood-vessels were constricted—not dilated, as generally believed—and

both sweat- and sebaceous glands sometimes showed changes. No changes were found in the main nerve-trunks, but in the peripheral nerves pathological conditions could be demonstrated by Wolter's method,—*e.g.*, simple degenerative changes at the base of the bullæ, with hæmorrhage around and inflammatory changes in other peripheral nerves. In the spinal column he had observed degeneration of cells in the anterior columns and intermeningeal hæmorrhages.

He also described two epidemics of pemphigus neonatorum which had occurred in Gratz, all being of mild type, and five cases of dermatitis exfoliativa in young children observed in the last few years, invariably between May and August, all of which had begun by an eruption of bullæ lasting two or three weeks. Then the epidermis became sodden and could be picked up and detached in long strips. The disease could only be confounded with ichthyosis congenita sebacea.

Dr. Eppinger concluded that pemphigus was not a bacteriological disease, but probably the result of a toxic poisoning. He demonstrated (1) a case of so-called pemphigus—or essential shrinking—of the conjunctiva in an old woman who had had no true pemphigous manifestations elsewhere on the skin, and (2) a man with pemphigus of the axillæ, penis, and mucous membrane of the mouth.

Professor Petrini did not admit pemphigus acutus, pemphigus syphiliticus, nor pemphigus traumaticus as distinct diseases, and made the diagnosis of dermatitis herpetiformis in certain cases merely because it is the fashion to do so. He believed hydroa to be a different thing, and true pemphigus a grave and fatal disease.

Professor Schwimmer adopted views intermediate between those expounded by Kaposi and Duhring. He thought both pemphigus and dermatitis herpetiformis undoubtedly of nervous origin, but based his opinion as to their being different diseases mainly on their different prognosis.

Professor Neumann recognized pemphigus acutus as a distinct disease, as also pemphigus vegetans. He thought pemphigus foliaceus was merely pemphigus occurring in badly-nourished individuals, and he had never felt the necessity of making a diagnosis of dermatitis herpetiformis.

Professor Neisser thought that the expressions of opinion on both sides were exaggerated. He deprecated the tendency, characteristic of the modern Paris school, to invent new names and new diseases. He had frequently, however, met with cases which did not accord with the classical conception of pemphigus, and which he regarded as dermatitis herpetiformis. He put a direct question to Professor Kaposi as to his conclusion whether he had ever seen a single case which had gone through the phenomena attributed to dermatitis herpetiformis to become one of true pemphigus.—*British Journal of Dermatology*, November, 1895.

Tertiary Syphilis.—Dr. Caspary, of Königsberg, said that statistics have not proved that it is prevented by the intermittent treatment proposed by Fournier. He recommends the so-called symptomatic treatment in slight cases of secondary syphilis, and makes use of Fournier's method in grave secondary and tertiary forms.

DR. NEISSER said that the omission of energetic mercurial treatment during the early stage of syphilis seems to be the most important factor in the etiology of tertiary symptoms. Mercurial treatment should be commenced as soon as syphilis is satisfactorily diagnosed, and in this case it sometimes happens that no relapse occurs during ten years. A proof of the etiological relations between neglected or insufficient mercurial treatment during the early stage of the disease and the eventual occurrence of tertiary manifestations is the prevalence of endemic syphilis in localities where it is not methodically treated.—*Lancet*, November 9, 1895.

CONGRESS OF GERMAN NATURALISTS AND PHYSICIANS.

Treatment of Pyelitis.—HERR CASPER, of Berlin, reported two cases of pyelitis in which, by aid of the cystoscope, he passed a catheter through the orifices of the ureters and washed out the pelvis of the kidney. The first case was that of a man who suffered from pyelitis after gonorrhœal inflammation of the bladder. The catheter being passed into the pelvis of the kidney, it was retained there for several days and continuous washing of the kidney was carried out with solution of boric acid and nitrate of silver, until complete recovery took place. The second case was one of chronic pyelitis with commencing dilatation of the pelvis of the kidney. A catheter *à demeure* could not be made use of, and the kidney was catheterized every fourth day and washed out with a weak nitrate-of-silver solution. He recommended this method of treatment in all cases of pyelitis of gonorrhœal origin, and in acute cases in which improvement does not take place quickly. Cases of renal calculus, tumors, and tubercle are not suitable for this treatment.

Lumbar Puncture.—HERR QUINCKE, of Kiel, made a further communication on this subject, which appears to be attracting increasing attention, describing some technical improvements which he had made. He considered it all important, in every case in which the cerebro-spinal sac was punctured, to ascertain the degree of pressure within it. In all the cases punctured by himself he had succeeded in withdrawing fluid. The ordinary subcutaneous injection syringe was useless for the purpose, as pus would not flow through the cannula and the needle was also too short. Lumbar puncture was not only a valuable enrichment of our means of diagnosis, but had occasionally been of great therapeutic value. Thus, in acute serous meningitis considerable relief to the symptom followed the procedure.

PROF. VON ZIEMSSEN, of Munich, said that although the matter had not yet gone beyond the experimental stage, and we had yet to see whether direct medicamentation of the diseased spinal membranes would be possible, it could be said that the diagnostic and therapeutic value of lumbar puncture was beyond doubt. He did not use a trocar, but a simple Dieulafoy needle. The operation was especially difficult to perform in fat people without an anæsthetic, and he had decided to give one in all cases. He had never seen any ill consequences from the operation. He had seen good results therapeutically not only in a serous meningitis, but also in cerebro-spinal meningitis.

HERR LENHARTZ, of Leipzig, had performed puncture in fifteen patients, three of them cases of cerebro-spinal meningitis. He had never seen a positive result, although the needle certainly entered the spinal canal. He had never seen it followed by a distinct improvement. In one case of puncture he had succeeded in finding tubercle bacilli in the fluid withdrawn. —*Medical Press and Circular*, October 30, 1895.

GREAT BRITAIN.

BRITISH GYNÆCOLOGICAL SOCIETY.

Suggestions for Performing Abdominal Hysterectomy, with Five Successful Cases.—MR. F. BOWREMAN JESSETT pointed out that the methods of performing the operation might be divided into three classes: (1) extra-peritoneal method of dealing with the stump by the use of Koeberlé's clamp; (2) the subperitoneal method of dealing with the stump after removal of the tumor; (3) total extirpation. The objections to the extra-peritoneal and subperitoneal methods were discussed. By total extirpation of the whole organ all these objections were overcome, and the author submitted certain operative details which he had carried into practice with the most satisfactory results. Hitherto, operators, after removal of the entire uterus with its tumor, had laced or stitched the two peritoneal surfaces of the flaps together across the pelvis, thereby restoring the floor of the abdominal cavity. Difficulty had been experienced in opening up the roof of the vagina, some accomplishing this *per vaginam*, others by having an assistant's finger passed into the vagina. To overcome this difficulty, Mr. Jessett had had a bivalved speculum made, two inches long, which an assistant passed into the vagina when the tumor was delivered through the abdominal wound; by having this instrument pushed well home the roof of the vagina was put upon the stretch, and it was easy, after the anterior and posterior flaps were reflected from the tumor, to cut down upon the ends of the blades before and behind, and then to ligature the uterine arteries on each side; by dividing the tissues between these ligatures and the cervix the uterus and tumor were lifted out. By lacing the flaps across there was a large raw surface left, which would or might be a source of septic trouble afterward. To overcome this he proposed that long loops of silk, some four to six in number, should be passed through these flaps at their edge, so that the knot was made to come out through the speculum in the vagina by catching the loop in a specially-made instrument. When all these loops were passed they were drawn taut, and the peritoneal flaps were in this way everted and doubled upon themselves into the vaginal roof. The vagina was then packed with strips of iodoform gauze, the speculum withdrawn, and the abdominal wound closed. All the patients on whom Mr. Jessett had performed this operation had convalesced easily and well; in fact, just as after an ordinary ovariotomy or vaginal hysterectomy. He read short notes of five cases on whom he had operated successfully by this plan. The chief points in the operation were: 1. The use of the long

speculum passed up the vagina, by means of which the uterus is somewhat lifted up and the roof of the vagina put on the stretch, which enables the operator to cut with precision into the vagina from above. 2. The treatment of the peritoneal flaps; by everting and drawing these down through the vagina the two peritoneal surfaces are brought into accurate apposition, and, by being doubled on themselves, raw surface is apposed to raw surface, and, also, free drainage is established at the lowest point of the abdominal cavity,—through the vagina if required. 3. The flaps, being drawn down in this fashion, form a plug to the roof of the vagina, and the floor of the pelvic cavity is much firmer than if the peritoneum is simply laced across; moreover, by this method a large raw area is left which is much more likely to cause suppuration. 4. By removing the whole uterus in this manner there is very little hæmorrhage and no need for the use of elastic ligatures or other means for constricting the neck of the tumor. 5. The patients suffer no more pain or inconvenience after the operation than after an ordinary ovariotomy. There is no dragging on the stump, and the abdominal wound is not dragged in afterward as in those cases which have been treated by the serre-nœud.

Dr. Purcell said that the chief difference between Mr. Jessett's method and that of Martin, of Berlin, was that the former opened the vagina from above, whilst Martin worked from below. He called attention to the great advantages of Trendelenburg's position in this operation.

Mr. Taylor expressed the belief that no one method could be of general application. For instance, there were cases where the inversion of the broad ligaments would answer as well as the formation of flaps. Dr. Purcell was mistaken in supposing that Martin always adopted one method.

Dr. Bantock said that the operation would, in future, rest between extra-peritoneal treatment of the stump and total extirpation.—*British Medical Journal*, November 2, 1895

London Clinical Society.

Sudden Death from Cardiac Syphiloma.—Sir Dyce Duckworth described the case of a strongly-built man, aged 35, who was walking in the street, carrying his little boy, on October 7, 1894, when he suddenly fell down and expired. The body was carried to St. Bartholomew's Hospital, and was examined on October 9th. A very meagre antecedent history was obtained, which threw no light on the nature of the case. There was evidence of old syphilitic disease on the tongue and on the glans penis. A small gumma was found in the left lung. The heart weighed 22 ounces (700 grammes), and had firm adhesions to the pericardium, both at the apex and at the base. The right and left ventricles were hypertrophied and dilated. There was a round depression in the wall of the left ventricle above the apex, the diameter of a shilling, covered by long adhesions. This was due to a thinning of the wall, with much endocardial thickening. A large aneurismal pouch was found behind the posterior cusp of the mitral

valve. This appeared from without as a tumor growing from the base of the heart, completely covering the left auricle. Its walls were half an inch thick, and the pericardium was closely adherent over it. On section, the muscle was found to be replaced by tough, fibrous tissue, with foci of gelatinous matter. The endocardium was greatly thickened and fibrous. Microscopical examination proved it to be gummatous in nature, with patches of caseation. The smaller arteries showed signs of endarteritis. The appearances indicated plainly a recent gummatous growth at the base of the left ventricle, and a similar, but older, one near the apex of that cavity. The fact of sudden death as a frequent occurrence in cases of this nature was alluded to, and it was pointed out that these clinical features were but little known and necessarily but seldom recognized. The morbid anatomy was well understood. The author had collected particulars of fourteen similar cases, death occurring almost, if not quite, suddenly in eight of these cases. The disease was rare in women, only one of the fourteen having occurred in that sex. The mean age of all the patients was 32. Many of the cases appeared to have been previously devoid of urgent symptoms In some there had been pericardial pain. The speaker stated that graver symptoms were to be expected when fibrotic changes followed on the evolution of the gummatous growths, and when they led to aneurisms of the ventricular walls. The valves were usually not involved, and hence murmurs were not to be met with as in the case of rheumatic endocarditis. The ventricles and their septum were the common sites of these growths. Tendency to fatal and sudden syncope was probably explicable by the fact that endarteritis affected the coronary arteries in part, and possibly by the occurrence of embolisms from the softening contents of aneurisms into coronary arterial branches, the ventricular walls degenerating in consequence and becoming gradually intolerant of strain. The great object was to make an early diagnosis when possible, and to seek for syphilitic concomitants in cases where there were obvious cardiac symptoms, such as palpitation or infrequency of pulse, hypertrophy, dilatation, etc., and no signs of involvement of the valves. The treatment consisted in iodide of potassium in full doses.

Dr. Sidney Phillips said he had collected a large number of records of these cases. In one case, a man, aged 55, died suddenly, the only previous history being occasional pain in the chest to which no great attention had been paid. He remembered another case in which a man fell dead while crossing a field, and in that case no previous history could be obtained. The author's case was also without any previous history, but, on looking over the cases in which it was possible to obtain a history, he found that there had generally been symptoms of some kind. He thought that a great many cases of cardiac gumma might be diagnosed with a fair degree of certainty. In looking over the notes of fatal cases he found that it was most often at the apex of the left ventricle, which was what might be expected from what is known of the contraction of the heart. It was doubtful, indeed, whether aneurism of the heart, apart from injury, ever arose in any other way than from gumma. This fact is important, because if a diagnosis could be made it might be possible to avert this fatal complication. He recalled

the case of a young soldier who had contracted syphilis, for which he was treated for four years. Eighteen months later he was admitted to hospital with violent anginal symptoms, which, however, were not recognized as such, and he died in a few hours. It was then found that death was due to cardiac aneurism caused by gumma of the heart. It was, he added, well known that syphilis might give rise to dilatation or extreme hypertrophy of the heart.

Dr. Hale White observed that gumma of the heart was a rare thing, according to the returns which he had consulted, though syphilitic fibrosis of the heart, which might originally have been gummatous, was more common. They had at Guy's, on an average, not more than one a year. Though gumma was rarer than fibrosis, he did not think it possible to distinguish between a gummatous and a fibrous condition of the heart caused by treatment. The experience of nine cases known to himself showed that six died suddenly, and they bore out what Dr. Phillips had said, that if symptoms were looked for they could generally be discovered. Two of these had been attending hospital for some trivial ailment,—pain, shortness of breath, etc. The remaining four were picked up dead in the street, and the others were sufficiently ill to be in the hospital. Of these nine cases, four were absolutely certain and the other five were ailing more or less. Consequently, if a subject who was known to have had syphilis presented cardiac symptoms which could not be ascribed to any ordinary lesion, it was a fair inference that the syphilis was producing cardiac gumma or fibrosis. Nearly twenty years ago Dr. Fagge had collected a series of such cases, and his results were practically the same.—*Medical Press and Circular*, October 16, 1895.

ITALY.

Sixth Italian Congress of Internal Medicine, Rome.

Action of Toxic Products of Intestinal Putrefaction on the Liver and Kidneys.—Rovighi, of Bologna, gave the result of some experiments made by him on rabbits and guinea-pigs with indol, skatol, and phenol, with a view to determining the exactness of Hanot's assertion that the toxic products resulting from the process of intestinal putrefaction, when absorbed in large quantity and for a period of time, may cause certain forms of hepatitis. Rovighi found that indol and skatol produced analogous toxic effects in the organism,—viz., torpor, somnolence, generalized paresis, cardiac weakness, with lowered temperature and retention of the urine and fæces. The mortal dose for healthy adult rabbits is from 1.50 to 2 grammes (24 to 31 grains), injected under the skin within forty-eight hours; for guinea-pigs, about 1 gramme (15½ grains) injected in doses of 0.10 gramme (1¼ grains) daily. After the first doses the animals become more susceptible to the poison, as though they no longer have the power to transform and eliminate it. Histological examination of the liver of animals dead from acute poisoning by indol or skatol shows marked congestion of the portal and hepatic veins; in chronic poisoning, especially by indol, there is an infiltration of

the young cells around the biliary ducts and the intercellular spaces, while in the kidneys there is but a congestion of the vessels.

Phenol causes death in rabbits and guinea pigs in doses of 1.56 to 2 grammes (24 to 31 grains), injected under the skin, though it varies in different animals if fractional injections are made, guinea-pigs being able to support several grammes of phenol. The symptoms of acute phenol poisoning are: trembling, muscular contractions, tonic and clonic spasms, and, if the dose is mortal, a greater frequency of cardiac pulsations, followed by signs of considerable fall of blood-pressure. In chronic poisoning by daily doses of 0.10 to 0.20 gramme (1¾ to 3 grains) for two months the author noted emaciation co-existent with great hunger and occasional convulsions. The urine was rich in coloring matters. Autopsy in these cases showed notable alterations in the blood, which was black and slightly coagulable, the red corpuscles being destroyed; the liver was brownish in color and congested. On histological examination, the portal vessels were found gorged with blood and blood-pigment, the protoplasm of the cells presenting a state of cloudy swelling; around the biliary ducts there was some cellular infiltration. There were no important changes in the kidneys.

Injection of Iron Salts in Anæmia.—Riva-Rocci, of Turin, from his experience for the past six years, expressed the belief that the injection of iron salts, while improving and even sometimes curing anæmic conditions, does not combat the cause of the anæmia, and that this fact explains the frequent recurrence of the disease. It would appear from numerous researches that iron, introduced by injections, remains in the organism as an assimilable substance. Dynamically, it produces hyperæmia in various organs and tissues, favoring the resorption of œdema in anæmic patients, the destruction of old red corpuscles, and the formation of new hæmatins. He placed in the first rank heroic preparations of ammoniacal ferric citrate in 0.20- to 1-per-cent. solution, in doses of 0.05 to 0.30 gramme (¾ grain to 4½ grains). The administration of this drug sometimes causes nausea, vomiting, sneezing, and fever, but it is always possible to avoid local reaction.

A Case of Staphylococcæmia.—Feletti, of Catania, treated in his service a patient who succumbed to symptoms of progressive pernicious anæmia, and in whose blood the staphylococcus aureus and albus were found during life. Necropsy revealed a profound anæmia of all the organs, with fatty degeneration of the heart and considerable tumefaction of the spleen. There was no abscess. The author insisted upon the importance of the presence of staphylococci in the blood during life, for usually these are found only after death. It was also to be noted that the fever had assumed a continued type, while usually it is irregular. He did not attach much importance to the tumefaction of the spleen, since the patient had inhabited a malarious country.—*Semaine Médicale*, October 30, 1895.

Serum Therapy.—A discussion on this subject was opened by Professor Foa, Director of the Anatomico-Pathological Institute of Turin. After referring to his own investigations and to those of others, he summarized the present condition of the subject. Hitherto the most certain and effi-

cacious results have been from toxic infections; the latest researches, however, show the possibility of obtaining effects quite as certain in septic infections. The concept that every infection reduces itself to a pure poisoning, and that every reaction consists in the production of the counterpoison, is, perhaps, too absolute. In the case of diphtheria serum therapy has issued triumphant from the test of practice, and statistics show the sensible diminution of the mortality obtained by the new treatment. Serum therapy has been less efficacious in acute cases of tetanus. The tetanic manifestations in such cases would indicate grave organic lesions already complete, against which serum therapy cannot cope; it is, however, the best preventive remedy. In typhoid and cholera it has not found any application up to the present time, probably owing to the notable difference between experimental results and the natural condition of the infections in man. The latest researches of Foà have solved the problem of serotherapeutics in diplococcic infection of the rabbit; it remains to study the problem in the larger animals, which permit of the results being applied to man. Serum therapy must not be allowed to hinder the development of prophylaxis. Both aim at the prevention of diseases, and serum therapy, where it shows itself in preventive immunization, becomes a prophylactic measure.

Professor Maragliano, Director of the Institute of Clinical Medicine, Genoa, referred to his researches on tuberculosis. He said he had clearly explained the materials used in the vaccinations, and summarized the new results obtained with his treatment by many Italian and foreign physicians. A total of two hundred and fifteen cases had been reported up to date, of most diverse character, and all confirming the value of the treatment. He concluded his address with the following propositions: 1. Therapeutic serums, to develop their special action, require the active concurrence of the affected organism. 2. The value of serum therapy can be determined only by clinical observation. 3. Serum therapy can develop its special action as much in acute as in chronic infections. 4. The therapeutic serums introduced up to the present in practice in Europe are absolutely innocuous. 5. Serum therapy in its clinical application has up to now given indeterminate results in streptococcic and typhoid infections, doubtful in tetanus, promising in pneumonia, which awaits only a methodical clinical consecration; positive in tuberculosis, which only wants the confirmation of an extensive trial; incontestable and surely triumphant in diphtheria.

The only disappointment in connection with the congress was that Professor Maragliano did not explain his method of obtaining the antituberculous serum, as many of the members had expected he would do.—*British Medical Journal*, November 2, 1895.

Gastric Catarrh.—For cases with deficient motility and deficient secretory activity: ℞ *Nitrohydrochloric acid*, 1½ fluidrachms (6 grammes); *tincture of nux vomica*, 6 fluidrachms (23 grammes). Mix. Fifteen drops before or after meals. The mixture is explosive under certain conditions, and should be kept in a cool place, in the dark. (Eshner, *Polyclinic*, September 28, 1895.)

UNITED STATES.

Medical Society of Virginia.

Pyæmia and Septicæmia.—Prof. J. McFadden Gaston, of Atlanta, in a paper on this subject, said that the relation of bacteria to diseased processes in the organism depend, to a very large extent, upon the predispositions of the structures to take on disease, and upon the development of leucocytes which arrest the morbid element. It is held generally by bacteriologists that the predominance of phagocytes in the tissues, which may be involved, prevents the hurtful influence of bacteria, and that the phagocytal process serves as a prophylactic against structural disorders. Indeed, it is questionable whether active, living micro-organisms cause disease, and it may be fairly inferred that the loss of vitality in the micrococci is the source of trouble in most cases of morbid developments.

This lends force to the view that ptomaines have an important rôle in the disorders of the physical organization, and the impression has been growing that this is the septic element in the suppurative and destructive results of any contamination from without. It is evident that ptomaines contribute chiefly to the development of septicæmia in most cases.

That pyæmia may occur independent of any ptomaine element is a fair inference from the history of cases in which purulent absorption seems to account satisfactorily for the train of disorders which are observed. In the cases of multiple abscess which are developed from a purulent focus, there is no reason to doubt that pus has entered the lymphatic system, and, being arrested at certain points, leads to local collections of a purulent character. These abscesses conform in most respects to the characteristics of what is known as cold abscess, partaking of the nature of chronic abscesses, and are rarely accompanied with the acute inflammatory manifestations of phlegmonous abscesses. When a purulent focus leads to the absorption of pus, there must be a deficient formation of that protecting sac known as the pyogenic membrane, and consequently the purulent collection escapes into the cellular tissue, and is taken up by the lymphatics and conveyed to the blood-vessels or the capillaries; it thus becomes absorbed and in some way develops pyæmia.

The indications at the outset, when there is local irritation at the point of injury, is to incise the affected part and cauterize with carbolic acid, applying to the adjacent area an ointment containing equal parts of the following: ℞ Ung. hydrarg., ung. iodi. compos., ung. camph., ung. bellad. A poultice of flaxseed-meal may cover the inflamed structures, and be renewed frequently to keep up heat and moisture.

If there should follow much swelling and great tension, incisions should be made freely to relieve the constriction and give an outlet to the serosanguinolent accumulations. This course is more especially indicated when the hand is involved; and when the inflammation extends up the arm, involving the axillary glands, the ointment and poultice should be carried up to the shoulder, so as to cover the entire arm.

If the case progress favorably, there may be no accumulation of pus

above the elbow; but if abscesses form, they should be promptly evacuated and washed out with antiseptic solutions.

The proper sphere of real antiseptic surgery comes into play with pyæmia and septicæmia, as there are pre-eminently septic developments which require the use of measures to counteract the contamination of the organism. Not only in the local but in the general manifestations is sepsis to be combated, and hence it becomes requisite to correct the secretions and stay the invasion of the organs by internal antiseptic remedies. Some have regarded alcoholic treatment as indicated from the outset of the disorder, and that nourishment of a character to prevent the waste of tissues should be combined with the alcoholic stimulant. The mixture of milk and whisky or brandy, in form of milk-punch, is found to meet the requirements satisfactorily as a routine diet. But it is desirable to supplement this with beef-soup, corn-meal gruel, malt, and fresh vegetables, suited to the state of the digestive organs and to the powers of assimilation. It is a matter of paramount importance to sustain the physical organization throughout the septic process.

Long Survival After Injury of the Spinal Cord in the Cervical Region.—Dr. James L. Kent, of Bertha, Va., gave the notes of a case of rupture of the posterior common ligament between the sixth and seventh cervical vertebræ. The cord was normal except for a space of about an inch, beginning opposite the articulation of the body of the sixth or that of the seventh cervical vertebra, and extending upward to near the origin of the sixth cervical nerves. For this distance the membranes of the cord were not broken, and showed only slight signs of an old inflammation; but the substance of the cord was of the consistence of thick cream, and extended from the roots of the nerves as they were severed, leaving nothing but the connective tissue and membranes, which formed a thin, flabby connection for the two ends of the cord. From the evidence at the time of injury and at the autopsy, it was concluded that the weight of the body was thrown on the forehead in such a way as to lift the sixth vertebra up and slide it back over the seventh, as there were dirty cuts on the forehead and nose, and the posterior common ligament was torn through, while the ligamentum nuchæ was intact. The patient lived seven weeks after the injury.—*Virginia Medical Monthly*, October, 1895.

American Laryngological Association.

Thyroid Extract in Goitre.—From a consideration of the history of this subject and an analysis of cases presented by him to the society, Dr. E. Fletcher Ingals, of Chicago, drew the following conclusions (*N. Y. Med. Jour.*, Sept. 7, 1895): 1. Thyroid products produce marked physiological effects upon the nervous and circulatory systems, as indicated by headache, dizziness, pains in other portions of the body, and great weakness, and by flushing of the face and rapidity of the heart's action. 2. Some of these unpleasant symptoms usually occur when a daily dose is reached corresponding to one and a half or two entire thyroid glands of the sheep. 3.

If the administration of the remedy in doses that cause such symptoms is continued for a few days, constitutional effects are produced, indicating that persistent use of doses of from 6 to 12 grains (0.39 to 0.78 gramme) of the dried thyroid (equivalent to one or two thyroid glands) three times daily might produce fatal results. 4. Desiccated thyroid glands appear quite as active as the liquid extracts, and are more stable. 5. Internal administration appears quite as effective as hypodermatic medication. 6. For internal use, the adult dose of the desiccated thyroids should not exceed 2 grains (0.13 gramme) three times daily at first, but the dose may be gradually increased to two or three times this quantity, provided it does not cause unpleasant symptoms. There is no evidence that moderate doses have an injurious effect. 7. The remedy in some cases has a pronounced effect on the body-weight, but this is very uncertain and varies so greatly in different persons, and in the same individual at different times, that there is strong reason for suspecting that the loss of weight which sometimes follows this administration may be due entirely to disturbance of the digestive organs. 8. In the treatment of myxœdema it has undoubted value, and appears to benefit quite a large percentage. In these cases it is probable that the best results will be obtained by giving it at intervals for a long time. 9. In exophthalmic goitre it causes rapid reduction in the size of the gland, but it has no perceptible effect upon the exophthalmia, and it apparently aggravates the heart-symptoms. In this disease it must be used guardedly and its effects must be carefully watched. 10. In many cases of goitre internal administration of full doses of the products of the thyroid is followed by a most remarkable diminution in the size of the diseased gland. Improvement or cure may confidently be expected in 76 per cent. of the cases, but sufficient time has not yet elapsed to determine what the final results will be. It is probable that cystic growths in the thyroid gland would not be influenced by this remedy. 11. Clinical experience has not yet demonstrated that this remedy is of value in other diseases, but its effect in diminishing the size even of very firm and hard enlargement of the thyroid gland would certainly justify experimentation in other directions.

New York State Medical Association.

Malignant Tumors.—Dr. Edward K. Dunham discussed the metastatic nature of tumors, which he regarded as peculiar to those of malignant form alone; their mode of extension and transplantation, which he attributed to cell-transplantation and growth under new surroundings; also the commoner sites of tumors, which he explained in the case of recurrence on the basis of the usual channels through which the cells were transported. While cases of metastasis of benign tumors, such as cartilaginous tumors which had a high cell-organization, had been reported, Dr. Dunham had come to the conclusion, on studying these, that they were really mixed tumors containing sarcomatous elements, and that therefore they did not constitute exceptions to the rule that metastasis was a sign of malignancy. He regarded the susceptibility of malignant tumors to metastasis to be dependent

upon their cellular structure, with little or none of the intercellular substance characteristic of other tissues. In a great many instances the transported cells would die, and to this fact was to be attributed the usual failure of inoculation experiments, especially in animals of different species. In the same individual the time of metastasis appeared to bear no relation to the duration of the primary neoplasm nor to its size. As soon as the tumor formed, it was liable to metastasis. No more conclusive argument could be offered in favor of prompt operative interference.

Dr. Chas. Phelps considered the early detection and prompt ablation of tumors. To those who held that all tumors should be removed at once, diagnosis of the nature of the growth was not so important; to those who held that only malignant tumors should be removed at once, early diagnosis was extremely important. The contention that removal stimulated growth or extension of the disease seemed to him most irrational, and was not borne out by experience with radical operations. The possibility that all tumors might degenerate was admitted. It was a logical necessity that if malignant tumors required removal, safety demanded equally radical treatment of those other structures which might assume the character of malignancy even while we hesitated. It was hard to remove the breast of a young unmarried woman when it contained an adenoma, but an experience like one which he related, of a change to carcinoma within a few months and death after prolonged and severe suffering, would convert one to the surgical treatment.

Dr. J. W. S. Gouley stated that it was of prime importance for physicians to understand that partial extirpation and caustics favored spreading the disease. Benign tumors were liable to become malignant, and should be removed. It was possible, he thought, for a malignant tumor, or one of low organization, to take on the higher organization of the benign forms, or at least to become so far transformed as to remain quiescent a long time. Yet the oft-repeated dictum, that so long as a tumor remained stationary and caused no inconvenience it should not be removed, was contrary to the true principles of conservatism, and was fraught with the greatest danger to the patient. Early removal was likewise indicated whenever recurrence took place. None of the so-called specifics for malignant disease had ever been of any service.

Dr. Joseph D. Bryant, in considering the prognosis of malignant tumors as modified by their management, recommended the early removal of all malignant tumors, and, indeed, of all tumors of whatever nature, as a form of prophylaxis. Tabulated statistics were given, showing that malignant disease was on the increase in the human family. In the United States the mortality from this cause in 1850 was 9 for 100,000 living; in 1860 it was 11.7; in 1870, 16; in 1880, 26; in 1890, 33.5. This difference could not be entirely due to a fuller report of cases for the later decades. The death-rate from malignant disease was greater in the cities than in the country. The increase had been shown in all parts of the body, but not in equal proportion. In the parts most commonly affected, as the genitals and breasts of women, the increase had not been so rapid as in the ali-

mentary tract. The organs of most physiological significance were most involved. The increase was greatest with increasing years, which was against the theory of infection as more than a rare cause at best. Germans were more often affected than the Italians or Irish in New York. The importance of removing enlarged or neighboring lymphatics while removing the tumor was shown by earlier recurrence and earlier death where this was not done. The advantages of removal by the knife over caustics were that it could be done quickly, cleanly, completely, circumscribedly, securing early healing of the wound and avoiding irritation and spreading the disease. The patient should be impressed with the necessity for remaining under observation, and of speedy removal should there be recurrence. Everything lowering the health should be avoided. After removal, special internal remedies might, at times, be used with discretion,—arsenic, mercury, etc. They should never be employed as a substitute for the knife, but simply as an aid.

Dr. Parker Syms urged surgical treatment for the following purposes: 1. Thorough removal of all visible disease. 2. Thorough removal of all invisible disease; hence, removal of tissue surrounding the growth. 3. Removal of the neighboring lymphatic system. 4. Removal of the disease *en masse* as far as possible, so as to avoid cutting into and liberating infectious elements. 5. Preservation of the patient's strength as far as possible. 6. Ablation of the disease in the early stages.

Dr. Frederick H. Wiggin pointed out that less frequent recurrence or prolonged life obtained by recent surgery was due to a cleaner, more radical operation, as well as to an earlier one. Sir Astley Cooper had demonstrated that the radicles of the disease spread out and that the lymphatics were involved, and he advised removal of these; but many years elapsed before his advice was followed. Halsted, Curtis, and Meyer had reported little deformity or disturbance of function from so radical an operation as removal of the pectoral muscle in addition to the tumor and lymphatics. As to rapid cicatrization of the wound, while it was important that the wound should heal as rapidly as possible, yet it was secondary in importance to removal of parts adjacent to the tumor.

Dr. F. S. Dennis expressed the belief that there was little to be hoped or expected from the administration of constitutional remedies, and believed that where there had been a result it had been due more to the radical character of the preceding operation than to the drug. If the drug produced an effect, it was probably as a tonic, enabling the patient to resist the advance of the disease. It was a question whether iodide of potash had not some influence on sarcomata; but disappearance under its use might have been spontaneous, as sometimes occurred with no treatment. Cicatricial contraction was not to be confounded with disappearance,—a mistake which some made in lauding a remedy. Dr. Dennis impressed upon his hearers the necessity of keeping an accurate systematic history of every case of tumor from the beginning. A photograph should also be taken. The condition present after operation should be recorded at stated intervals. Prompt removal should be the rule in cases of recurrence, and the

need of this should be impressed upon the patient. Like Dr. Wiggin, he placed three years as the period after which recurrence was not likely to take place,—say, in only 2 per cent. of the cases.

Dr. W. B. Coley gave his experience with toxins, mostly mixed toxins, of erysipelas and bacillus prodigiosus, in the treatment of malignant tumors, during over four years at the New York Cancer Hospital. He does not claim that all cases of cancer can be cured by the toxin treatment, but only gives to the profession the results which have been reached by the use of the erysipelas serum and other toxins. He has had good results in many cases of both sarcoma and carcinoma. In some cases the patients have been greatly benefited by the treatment, and their lives have been certainly prolonged, if an entire cure has not been achieved. In the most successful cases the malignant growths have been entirely abated, no symptoms of their presence can be detected by the most rigorous examination, and the patients are in apparently perfect health. There has been no recurrence of the cancerous growth since the cessation of the treatment, although this ranges in the different cases from seven months to three years. The reason that other practitioners have not been as successful and have not achieved such good results as he is able to report, he thinks, can probably be traced to the fact either that the treatment has been slip-shod or has not been sufficiently persisted in. All the cases which he has treated successfully have been pronounced inoperable by the best authorities in New York and other cities, owing to the position of the malignant growths or other conditions. Several of the patients had been operated on previously, and came under his care at the hospital on a recurrence of the cancer. In cases where the toxin treatment was successful, the patients are now going about apparently in perfect health.

Dr. Coley then enumerated eight cases which had been treated by him with success, detailing at length the condition of the patients when they came into his hands, the exact nature of the malignant growth from which they suffered, and the course of treatment pursued in each case. Six patients who had been successfully treated—four women and two men—visited the hall, and the members subjected them to a rigorous inspection.

Medical Society of the County of New York.

Asepsis and Antisepsis in Midwifery.—Dr. A. Y. Reid compared the methods and results of aseptic and antiseptic midwifery as practiced in city institutions of New York with the same in the private practice of four physicians. The institutions included the Sloane Maternity, the City Maternity on Blackwell's Island, and the Lying-in Hospital for the Instruction of Medical Students at Seventeenth Street and Second Avenue. In the first named there had been but 3 deaths out of over 4000 cases, and in these 3 infection had taken place before admission. There had been no deaths in the last 1000 cases confined at the City Maternity. The mortality-rate in the several institutions named, under present aseptic and antiseptic methods, was about one-eighth of 1 per cent., while that in the practice of

the four physicians quoted was about one-fifth of ·1 per cent. in a total of nearly 1000 confinements. Dr. John Woodman had had no deaths from sepsis in his last 150 cases; Dr. Reid but 1 in his last 458 cases. The chief difference in the methods of aseptic and antiseptic practice in the institutions and in the hands of the private practitioner was the omission by the latter of the vaginal douche before and after labor. Whenever possible, Dr. Reid insisted on cleanliness of clothing, bed-linen, towels, and napkins; washing of the external genitals with soap and water and some antiseptic; cleansing and disinfection of hands and instruments. The physician seldom arrived before the woman was in labor, and the surroundings were not such as to enable him to give a vaginal douche without liability of defeating the purpose for which it was intended,—disinfection and asepsis. Nor was it practical to shave the pubes, as was done in hospitals. He would irrigate the vagina subsequent to labor only in case of rents, and the uterus only after introduction of the hand, using then a 1 to 10,000 bichloride solution. If no complication arose, the patient was allowed to get up on the ninth or tenth day. While he did not object to the details of hospital asepsis being attempted in private practice, yet he did not think all of them necessary.

Dr. J. H. Garrigues stated that before he had introduced antiseptic methods into the New York Maternity, October 1, 1893, the mortality had been about 5 per cent. During the last month prior to their introduction it had been 20 per cent.; for four months after introducing antiseptic methods no deaths occurred.

Dr. R. A. Murray called attention to the fact that the worst cases of midwifery occurred usually in maternity hospitals; yet these now gave a smaller mortality-rate than was seen in private practice. The reason was that in private practice physicians did not do what they ought to secure asepsis. When the physician kept himself and his hands clean sepsis did not occur, no matter what the surroundings of the patient. The genitals should be cleansed with soap and water, but the vaginal douche was not necessary. He used carbolic acid or creasote for the hands, kept the bed as clean as possible, and especially had antiseptic napkins for use immediately after expulsion of the child. The nurse should not examine the patient. He had yet to see his first case of sepsis in his own private practice.

Dr. E. A. Tucker would not advise the uterine douche unless a foul fœtus had been expelled, or some such indication was present. Shaving the pubic hair could be done in a hospital, but it was not necessary in private practice.

Dr. Thomas Darlington said that in country or sparsely-settled districts he frequently found none of the conditions permitting of antisepsis as practiced in the maternities. Sometimes there was an absence of soap, of boiled water, or water of any kind. He had confined nearly 1000 women, and had lost none from any cause. Whenever there was sepsis, it came from the physician, not from the patient. He carried bichloride tablets, and cleansed and disinfected his hands. He thought the vaginal secretions helped the passage of the head, and that the douche retarded it.

DR. ROSENBERG thought that there was danger of infecting the woman by giving the vaginal douche. The secret of puerperal infection was easily understood after one came to realize that the womb was absolutely aseptic, and that manipulations and douches were both unnecessary and harmful.—*Medical Record*, October 5, 1895.

Selections from Reports of Members of the Annual's Staff of Correspondents.

Sweden.

DR. F. EKLUND,
Brefväxlande Medarbetare för den
SVENSK MEDICINSK LITTERATUR.

Af alla i Sverge utkommande medicinska tidskrifter, bocker, afhandligar, monographier a. s. v. torde ett exemplar benäget öfversändas till

DR. ABRAHAM FREDRIK EKLUND,
Sibyllegatan, 3 A,
Stockholm.

Primary Acute Endocarditis.—H. KÖSTER (*Läkaresallskaps förhand.*, vol. ii, p. 1, 1894) describes the case of a woman, 29 years of age, who had suffered several times from acute articular rheumatism, the first attack occurring about the age of 10 years and the second from three to five years later. Since that time she had suffered from palpitation of the heart until last year, when she was attacked with rheumatism. This was followed by considerable disturbance of cardiac function, acute pains in the chest, dyspnœa, and emaciation. Typical symptoms of acute endocarditis of the pulmonary valve were present,—cardiac dullness, increasing toward the right, evidently due to dilatation of the right heart; a diastolic blowing sound over the pulmonary artery in the second left interspace only; absence of the second sound, and a broad, powerful cardiac impulse. Post-mortem examination showed acute endocarditis involving only the pulmonary valves and contiguous portions of the pulmonary artery, with a serous pleuritic effusion, ascites, marked development of connective tissue, fatty degeneration of the liver, chronic parenchymatous nephritis, and pericarditis. A growth, with point of departure in the inferior valve, occupied the pulmonary valves. It was about the size of a pigeon's egg, rough, villous, and studded with calcareous deposits in some parts and of very soft consistence in others. Similar vegetations, though considerably smaller, were situated on the endocardium, in the right ventricle near the valves, and on the intima of the pulmonary artery.

The Staining of Blood for Clinical Purposes.—ARNOLD JOSEPHSON, of Gothenburg (*Göteborg's läkaresallskaps förhandlingar*, No. 2, p. 32, 1894), makes use of the following simple method of staining blood-preparations, and finds that it is very convenient, as it requires only about five minutes' time. The air-dried preparation is passed rapidly through the flame of a spirit-lamp a few times, immersed in ether-alcohol, and again dried in the air. It is then immersed in a 2-per-cent. solution of eosin, washed off quickly in water, air-dried, immersed one-half minute in a saturated solution

of methylene-blue, washed off in water, again dried, and placed in Canada balsam. The formation of the red corpuscles is somewhat altered by passing through the flame, but they absorb eosin as readily as before, the eosinophile cells especially taking on a beautiful color. It is best to examine the preparation immediately after it has been made, as the eosin stain disappears very soon. The dry preparation can be preserved for a long time without diminution of the faculty for absorbing color. The author has observed three cases of pernicious anæmia with two deaths, and was not able to find a single eosinophile cell in the blood in any of the cases, nor in the bone-marrow seven hours after death in one case. On the other hand, he has always met with them in anæmia not of a pernicious nature, as in tuberculosis, cancer, gastric ulcer, etc. In two cases of acute tumefaction of the spleen in ileotyphus and one of malaria he did not observe an increase in the number of eosinophile cells, while there was a considerable augmentation in a case of tumor of the spleen following malaria. These examinations were made by the above method, and Josephson remarks that, practically as well as scientifically, it is of value as enabling a distinct differentiation to be made between anæmias of different nature, or between leucocytosis and beginning leukæmia.

Successful Cæsarian Section.—CHARLES DAHLGREN (*Upsala läk. förhand.*, vol. xxx, Nos. 5 and 6) reports the case of a workman's wife, III-para, aged 23 years, small and puny, and in the tenth month of pregnancy, who presented a hard, fixed tumor of the left side of the pelvis. The tip of the index finger could be introduced between the tumor on one side, and the sacral bone, the lesser sacro-sciatic ligament, and the tuberosity of the ischium on the other. The tumor was divided into two parts,—one larger and vascular, reaching to the umbilicus; the other firm and hard and about the size of an orange, situated below. Between the tumor and the right pelvic wall there was space for three fingers. Beyond the spina ischii the tumor had grown fast to the pelvic wall. Porro's operation was performed before the beginning of labor-pains, the result being favorable to both mother and child.

Lysol in Obstetrics.—C. M. GROTH (*Svenska läk. förhand.*, p. 20, 1895) gives the statistics of the Southern Lying-in Hospital of Stockholm, where, since the last death from puerperal fever, 4000 women have been delivered, the conditions leaving nothing to be desired. For the past few years the strongest solution of lysol, the antiseptic used, has been 1 per cent. externally and 0.5 per cent. for injections. The students in midwifery pay great attention to the study of external manipulation in order to restrict as much as possible internal manœuvres. Forceps were applied on account of insufficient labor-pains before the introduction of antiseptics, 24 times in 1000 cases; after the introduction of antiseptics, 18 times per 1000; during the first year in which lysol was used, 5 times; during the past two years, 12 times per 1000.

Clinical Notes.

Vaginal Cancer.—Primary cancer of the vagina is stated by most authors to be relatively rare, though the great scarcity of cases, according to Dr. LABUSQUIÈRE, of Paris (*Annales de Gyn.*, September, 1895), may, to a certain extent, depend upon the slow evolution of the affection, many women only seeking help when the process has extended to the uterus and sometimes to the parametrium. Under these conditions it is much more difficult to determine the exact site of the primary disease, or is perhaps deemed useless, since the case is regarded *a priori* as inoperable. Martin observed the condition but once among 5000 women, and OLSHAUSEN, in a recent article (*Cent. f. Gyn.*, No. 1, 1895), states that but 18 cases were observed at the Frauenklinik of Berlin between 1886 and 1894. In 13 of these cases the neoplasm had developed on the posterior wall of the vagina,—the usual location, according to most writers. All are in accord as to the gravity of the affection, and its tendency to recur after the usual surgical intervention, no matter how thoroughly this may be done. It seems impossible to prevent the inoculation of healthy tissues, and it is with this end in view that Olshausen has recommended operating in such cases by the perineal method. He records three instances in which he made use of an adaptation of the perineotomy invented by Zuckerkandl for extirpation of the uterus. He first divided the perineal body transversely and then separated the posterior vaginal wall from the rectum by means of the blunt director and finger, not opening the peritoneal cavity if the uterus was to remain in position. He then made lateral incisions and removed the diseased mass with scissors, carefully suturing the cut edges together and to the rectal wall. In the discussion of a paper upon the subject presented by Olshausen to the Berlin Medical Society, GOTTSCHALK recalled the fact that Fenger, of Chicago, had, in 1893, published a case successfully operated on by the perineal method. The advantages, according to Olshausen, are that separation of the diseased portion of the vagina, the opening of Douglas's *cul-de-sac* when necessary, and the partial liberation of the uterus from its ligaments is effected without contact with the neoplasm, while, in addition, the operator has much more space to work in and is able to more easily and surely circumscribe and excise the degenerated portions of the vagina.

DUHRSSEN (*Cent. f. Gyn.*, No. 9, 1895) prefers to this procedure one derived from his own method of wide vaginal incisions, of which he has made various applications in gynæcology and obstetrics. The principal feature consists in a deep vagino-perineal incision, from the vaginal *cul-de-sac* to the fourchette, and from there backward in a line going from the anus to the ischium. He performed this operation in a case in which the right half of the posterior wall of the vagina was involved, remarking that, as more radical measures could not here be used, his method was justified by the hæmorrhage and intolerable pain from which the patient was thus relieved. When total extirpation of the uterus is necessary, high amputation of the cervix had better be performed; but, contrary to Olshausen, Dührssen does not believe that total hysterectomy is always necessary when the uterus is involved, the parametrium being affected not by extension of the

lesion from the vaginal portion of the cervix, but by direct propagation of the vaginal disease.

W. THORN (*Cent. f. Gyn.*, No. 9, 1895) states that he used the perineal method in two cases, in 1889 and 1891, using a technique very similar to that described by Olshausen. One of his patients survived two years, the other one year.

H. THOMSON, of Odessa (*Cent. f. Gyn.*, No. 22, 1895) reports that after the communication of Olshausen, but before those of Dührssen and Thorn, he had had occasion to perform a similar operation to that of Dührssen, but, as the neoplasm involved the two lateral walls, he made an incision first in the median line. The results were good, and the patient appeared to be in good health some weeks later; however, the case is too recent to permit of a definite judgment as to the ultimate result. Thomson concludes that, in cases of extension to the vaginal portio, high amputation of the cervix, according to Dührssen's method, is generally sufficient; that in a general way the latter's operation is preferable to Olshausen's and involves less mutilation; and that, while the perineal method is especially indicated in carcinoma situated low down, the sacral method of Fritsch and Thorn is more suitable for cases of extensive vaginal degeneration.

Fatal Acute Poisoning by Cocaine.—DR. O. H. GARLAND, of Leith, relates the following case, of some medico-legal interest owing to the few fatal cases of the kind recorded: "About 3.30 P.M., on Monday, October 7, 1895, at the request of the authorities, I made a superficial examination of the body of a young woman who had at about 7 A.M. swallowed, for the relief of toothache, upward of 2 fluidrachms (8 cubic centimetres) of a 10-per-cent. solution of the hydrochlorate of cocaine,—the equivalent of 12 to 15 grains (0.78 to 1 gramme) of the alkaloid. She had almost immediately afterward suffered from vertigo, followed by epileptiform convulsions, nine in number, occurring in somewhat quick succession, and died within forty minutes. She appeared to be about 17 years of age, and the body was well nourished. The trunk still contained a considerable degree of warmth, but the extremities were cold, rigor mortis being well developed in all of them. The face, lips, and anterior surface of the body were very pallid and wax-like, while on the dependent portions well-marked cutaneous hypostasis was present. The expression of countenance was placid. The pupils were dilated and the conjunctivæ were not injected. The teeth were firmly clenched. On the following day (Tuesday), as further instructed, I made a post-mortem examination. The external appearances remained as described. Frothy mucus, slightly blood-stained, was freely exuding from the right nostril. The brain was anæmic, but otherwise normal. The meninges were deeply congested. The heart was healthy in substance, and all the valves were found to be competent. The right ventricle contained a small quantity of dark-colored fluid blood, the left ventricle was quite empty. Both ventricular walls were relaxed. The lungs were too much congested throughout and everywhere highly crepitant. A considerable amount of frothy mucus, in part blood-stained, was present in the bronchi. The liver, spleen, and kidneys were hyperæmic, but otherwise normal. The

stomach and contents were removed and preserved intact for expert analysis; consequently there was no opportunity afforded for inspection of the mucous surface of that organ. The bladder contained from three to four ounces of urine. All the other organs were normal." The case, according to the author, lends support to the view of Mannheim, that 15 grains (1 gramme) of cocaine constituted a fatal dose. In the present state of our knowledge it is, however, practically impossible to state the smallest lethal dose, seeing that a dose of $\frac{2}{3}$ grain (0.04 gramme) has caused death and so minute a dose as $\frac{1}{100}$ grain (0.00065 gramme) has given rise to symptoms threatening life. —*Lancet*, November 2, 1895.

Tuberculosis of the Stomach.—Tuberculous lesions of the stomach are very rare, LETOREY, in his *Thèse de Paris* (1895), being able to collect only twenty-one cases. This rarity is explained by the action of the gastric juice on the Koch bacillus, which either dies or loses its virulence in an acid medium. Absence of hydrochloric acid, or its diminution, would, therefore, favor the development of tubercular lesions, as would also ulcer, gastritis, and particularly alcoholic gastritis. Some authors claim that the bacillus enters the stomach with the food, the ingestion of infected meat being the most frequent source; others assert that the swallowing of tuberculous sputum is the cause of the infection; Letorey, on his side, believes that the bacilli enter the stomach through the circulation. However this may be, tuberculosis of the stomach is nearly always secondary. Other important organs being involved, the lesion of the stomach, which presents no pathognomonic sign, passes unnoticed and is only discovered at autopsy. The usual site of the ulceration is near the pylorus and on the larger curvature. In only six cases out of the twenty-one was more than one such ulceration noted; so that the lesion may be said to be generally single, rounded or oval, with ragged and bleeding edges and a grayish-yellow base. The ulcer sometimes reaches a diameter of from three to five centimetres. The prognosis in these cases is grave, since the patient is generally cachectic and usually dies from the effects of the primary disease in the lungs or other organs, the gastric complication perhaps hastening the fatal issue.

In a case reported by ADAMI, of Montreal (*Montreal Med. Jour.*, March, 1895), an ulcer thirteen millimetres in diameter was found in the centre of the great curvature, in the muscular coat of the viscus, while corresponding to it in position upon the serous coat was an area of confluent tubercles. The patient was a girl of 10 years, who died from advanced and extremely generalized tuberculosis, which, from the caseous condition of the mesenteric glands, the author was inclined to regard as having first manifested itself in the alimentary tract, although it would certainly be possible to urge also that the disease began in the lungs.

Tuberculosis of the Tongue.—Tuberculous ulcerations of the tongue are most frequently observed in patients in the last stage of phthisis, and side by side with affections of the same nature situated on the inner surface of the cheeks, tonsils, and lips. It is but rarely that the disease is limited to the tongue in persons manifesting no tuberculous disease in other organs. The difficulty of recognizing such cases makes a knowledge of the symp-

tomatology, diagnosis, and evolution of considerable importance. WEDENSKI (*Med. Oboz.*, No. 3, 1895) tells us, apropos of two cases observed by himself and one hundred and twelve collected from literature, that it appears in two forms,—the nodular in the thick portion of the tongue and the ulcerous form. Both may be either primary or secondary, though rarely the former. The affection occurs more frequently in man than in woman, from the age of 35 to 65 years. An early diagnosis is of great importance, as determining the proper line of treatment. The differential diagnosis must be made between carcinoma and syphilis, microscopical examination of curetted or excised portions aiding in forming it. Should the case prove to be one of local tuberculosis, surgical intervention would be the most rational treatment, and the earlier this is resorted to the less the chances of recurrence. Even in the secondary form it may be of value by ridding the organism of an infectious area, while clinical observation has proven that it does not aggravate tuberculous conditions elsewhere.

Tropical Liver-Abscess.—An experience of about forty cases of tropical abscess of the liver leads DR. NEIL MACLEOD, of Shanghai, China (*Lancet*, October 26, 1895), to regard it as rarely a primary affection and to believe that its relationship with dysentery is not one of coincidence merely. In all but one of his cases post-mortem signs of dysentery were found, the exceptional case recovering. Abscess is, to his mind, undoubtedly an unknown result of liver-congestion and inflammation in Great Britain, and he has never seen an abscess in tropical regions that could be attributed to congestion independently of dysentery. He has never seen a case of primary hepatitis pass on to suppuration. Singapore cannot be regarded as free from hepatitis by any means, but it is singularly free from liver-abscess and dysentery. The West Indies are not free from hepatitis, but hepatic abscess is rarely met with there. Of some one hundred and seventy-five cases studied by him from literature he can adduce no convincing proofs of the primary nature of the affection.

Recent Suggestions in Therapeutics.

Chloride-of-Ammonium Vapor in Middle-Ear Disease.—Whoever attaches a Richardson—continuous—spray apparatus by the proximal end of the elastic ball compressed by the hand to the distributing-tube of a Vereker chloride-of-ammonium inhaler, and lastly a Eustachian catheter to the distributing-end of the spray apparatus, will have a most efficient means of applying this gas to the middle ear. A few squeezes must first be given to the ball so as to fill the apparatus with gas before introducing the catheter. Again, if such a catheter or even a glass tube drawn to a point be affixed to a Higginson syringe, one of the best and handiest means of syringing the ear will be afforded. The small and practically continuous jet applied with any force de-

sirable almost immediately tunnels a hole in the hardest cerumen, and quickly allows of that reflex current necessary for its removal, doing away with the need for clumsy ear-syringes. (JAS. MACMUNN, *British Medical Journal*, October 19, 1895.)

Extra-uterine Gestation.—PROCHOWNIK advises vaginal injections of *morphine* to kill the embryo, as advocated by Winckel in 1889, one injection of 0.05 gramme ($\frac{7}{8}$ grain) in 2 grammes ($\frac{1}{2}$ fluidrachm) of water being sufficient. A strong needle, curved or straight, fitted directly on the syringe, must be used, antisepsis employed, and an iodoform tampon left in the vagina for twenty-four hours afterward. The method is contra-indicated after the twelfth week, or in cases of perimetritis or gonorrhœa. It is also of no value in cases in which abortion has begun, the decidua has come away, or where there is hæmatocele or hæmatoma. (*Berliner Klinik*, October, 1895.)

Gonorrhœa.—I. E. WILLIAMS, of St. Mary, O., offers the following suggestions in the abortive treatment by nitrate of silver, which he finds the most successful method: Do not obstruct the posterior urethra with the finger to prevent the fluid from reaching far back, as it can do no harm if the urine be passed immediately before injecting. The sphincters will guard the bladder. The injection should be held in for a few minutes by closing the meatus. In the beginning of an acute attack, before the discharge becomes purulent, give the following injection: ℞ *Argenti nit.*, 5 grains (0.32 gramme); *aquæ dest.*, 1 fluidounce (31 cubic centimetres). M. Sig.: Inject after urinating, every ten hours, until the discharge becomes purulent. Use a blunt-pointed syringe, holding 2 drachms. A *calomel purge* (5 grains) may be given with benefit, followed by *alkaline diluents* and *cannabis sativa* in small doses for four days. Then the following: ℞ *Plumbi acet.*, 20 grains (1.3 grammes); *zinc. acet.*, 12 grains (0.78 gramme); *aquæ dest.*, 1 fluidounce (31 cubic centimetres). M. Sig.: Inject four times a day after urinating. This injection should cause a slight burning sensation. If too severe, add $\frac{1}{2}$ ounce distilled water. If after using one or two days it cause no smarting at all, increase the *plumbi acet.* to 24 grains (1.5 grammes) to the ounce. (*Medical Record*, October 19, 1895.)

Infantile Broncho-Pneumonia.—For asphyxic symptoms: *Sodium benzoate*, 0.50 gramme ($7\frac{3}{4}$ grains); *acetate of ammonia*, 1.50 grammes (24 grains); *cognac*, 8 to 12 grammes (2 to 3 drachms); *gum mixture*, *syrup of Tolu*, each 45 grammes ($1\frac{1}{2}$ fluidounces). Dessertspoonful every hour or two according to age of child. For intense disseminated hyperæmia: *Powdered camphor*, 0.03 gramme ($\frac{1}{2}$ grain); *benzoic acid*, 0.15 to 0.20 gramme ($2\frac{1}{4}$ to 3 grains). To make one powder. Give in a glass of milk. For cardiac asthenia: *Tincture of digitalis* or injections of *caffeine*. Combat general intoxication by cold baths if the pulmonary lesions are not too extensive. (MARFAN, *Jour. des Prat.*, November 2, 1895.)

Purulent Ophthalmia.—*Permanganate of lime*, 20 grammes (5 drachms); *distilled water*, 300 grammes (9½ fluidounces). A large teaspoonful per litre (quart) of water. Each eye to be washed with 1½ litres (quarts) of this solution four times the first two days, three times daily the next few days, and twice daily until secretion ceases. If not cured within eighteen days, use *permanganate of potassium* instead of *lime*. Two hundred cases thus treated successfully at the Hospice des Quinze-Vingts. (KALT, *Bull. Méd.*, October 30, 1895.)

Recurrence of Malign Tumors After Operation.—Suggestions to the surgeon: Avoid breaking up the tumor if possible, so as not to infect the instruments, edges of the wound, and hands of surgeon and assistants; if by chance an instrument penetrate the tumor, sterilize the former at once before using it to continue the operation; in performing laparotomy for malignant visceral tumor, place compresses about the lips of the parietal wound to prevent all contact of the tumor with these lips, and their possible inoculation; sterilize the hands each time they are brought in direct contact with the surface of a section of the growth. (AIMÉ GUINARD, *Union Méd.*, September 28, 1895.)

Zona.—Keep the parts absolutely dry, and apply a sheet of wadding covered over with the following powder to ease the pain: *Starch-powder*, 60 grammes (2 ounces); *zinc oxide*, 15 to 20 grammes (3¾ to 5 drachms); *powdered camphor*, 1 to 3 grammes (15½ to 46 grains); *crude opium*, finely pulverized, 1 gramme (15½ grains). For the neuralgia which precedes and accompanies the eruption, give four pills daily, each containing *extract of datura stramonium*, *extract of hyoscyamus*, each 0.01 gramme (⅙ grain); *extract of belladonna*, 0.005 gramme (1/12 grain). For neuralgia consecutive to the eruption, subcutaneous injections of *antipyrin* or *glycerophosphate of sodium*. Begin all treatment by a saline purgative, preferably *sodium sulphate*. (A. ROBIN, *Bull. Gén. de Thér.*, October 30, 1895.)

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(End of Editorial Department of Journal for December, 1895.)

LACTOPHENIN: ANTIPYRETIC AND ANALGESIC.

In Sajous's "Annual of the Universal Medical Sciences," 1895, Dr. Dujardin-Beaumetz, editor of the department of Therapeutics (vol. v, A–92), gives this estimate of the therapeutic availability of Lactophenin:—

This subject is allied to phenacetin both chemically and therapeutically. It is a crystalline powder, with a somewhat bitter taste, and is very slightly soluble in water. According to Landowski, who tried it in Proust's clinic,[1] it acts precisely like phenacetin when both are given in 0 6-gramme (9¼ grains) doses, but 1 gramme (15½ grains) of lactophenin produces a decided hypnotic effect. Von Jaksch,[2] who employed it in doses of from ½ to 1 gramme (7¾ to 15½ grains) in typhoid fever, found that it always rapidly reduced the temperature, and also that it exercised a calming effect when there was restlessness or delirium. Jaquet, of Basel,[3] employed it in pneumonia, erysipelas, and influenza, and found it nearly always reduced the temperature rapidly and for some considerable time without any serious symptoms being produced; especially there was never any weakness of the heart's action or of respiration, nor any dyspnœa or collapse observed, and the pulse, as a rule, became fuller and slower, while the breathing remained unaffected. The great advantage of this drug appeared to be its calming, hypnotic effect, together with its reduction of the fever. The hypnotic value of lactophenin Jaquet estimates as intermediate between that of sulphonal and that of urethane. The usual dose employed by him was from 0.5 to 0.7 gramme (7¾ to 10¾ grains). H. Strauss[4] tried the drug as an antipyretic in twenty-five cases, finding it preferable to any other on account of its harmless nature. In typhoid fever it seemed to have a special calmative effect on the nervous system. Roth[5] used it in several cases of acute rheumatism, finding it equal to the salicylates. The pain and swelling disappeared within twenty-four to forty-eight hours, the temperature continued low, and no unpleasant effects were observed, though large doses were given.

[1] Lancet, London, April 21, 1894.
[2] Centralblatt fur Gynækologie, Leipzig, No. 14, 1894.
[3] Correspondenz-blatt fur Schweizer Aerzte, Basel, May, 1894
[4] Therapeutische Monatshefte, Berlin, September, 1894.
[5] Wiener klinische Wochenschrift, Vienna, September 13, 1894.

AMMONOL.

J. J. Sullivan, M.D., of New York, in writing of his treatment of suppressed menstruation, says that the age of the patient was 30 years, the wife of a mechanic, and was taken sick during the first twelve hours of her menstrual flow. The symptoms she complained of were suppression of the menses, pain over lower portion of abdomen, pain over liver at its lowest border, fever, frontal pain, nausea, and vomiting. She took to her bed and was unable to sleep or remain quiet for any length of time, and had complete anorexia. On this occasion Ammonol was used, instead of the well-known, time-honored remedies,—such as quinine, ipecac, morphia, hot fomentations over the abdomen, etc. He gave the patient about 10 grains of Ammonol, and, upon inquiry of her husband the next day, was told that he gave the wife the medicine according to directions, and about ten minutes later she fell into a quiet sleep and awoke next morning entirely cured of every symptom. The medicine had acted like a charm.

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